Docket for 02-1845

No. 02-1845 Status: ARGUED
Vide 03-83, 02-1826
Title: Aetna Health Inc., fka Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., Petitioner

v.

Juan Davila

Docketed: June 23, 2003
Lower Ct: United States Court of Appeals for the Fifth Circuit
Case Nos.: (01-10905)
Decision Date: September 17, 2002
Rehearing Denied: April 15, 2003
Questions Presented

~~Date~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~~~~~
Jun 20 2003	Petition for writ of certiorari filed. (Response due July 23, 2003)
Jul 17 2003	Order extending time to file response to petition to and including August 22, 2003.
Aug 21 2003	Brief of respondents Juan Davila, Aetna Health, Inc. and Cigna Heathcare of Texas, Inc. in opposition filed. VIDED.
Aug 22 2003	Motion for leave to file amici brief filed by American Association of Health Care Plans, Inc., The Chamber of Commerce of the United States, The American Benefits Council, and the National Association of Manufacturers.
Sep 2 2003	Reply of petitioners Aetna Health Inc., fka Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc. filed.
Sep 24 2003	DISTRIBUTED for Conference of October 10, 2003.
Oct 14 2003	DISTRIBUTED for Conference of October 17, 2003.
Oct 16 2003	Supplemental brief of petitioners Aetna Health Inc., fka Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc. filed. (Distributed).
Oct 27 2003	DISTRIBUTED for Conference of October 31, 2003.
Nov 3 2003	Motion for leave to file amici brief filed by American Association of Health Care Plans, Inc., The Chamber of Commerce of the United States, The American Benefits Council, and the National Association of Manufacturers GRANTED.
Nov 3 2003	Petition GRANTED the cases are consolidated and a total of one hour is allotted for oral argument.
Nov 26 2003	Consent to the filing of amicus briefs in support of either party or neither party received from counsel for the petitioners.
Dec 3 2003	Consent to the filing of amicus briefs in support of either party received from counsel for respondents Calad and Davila. VIDED.
Dec 18 2003	Brief amicus curiae of United States filed. VIDED.
Dec 18 2003	Joint appendix filed. VIDED.
Dec 18 2003	Brief of petitioner Aetna Health Inc., fka Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc. filed.
Dec 18 2003	Brief amici curiae of AAHP-HIAA, et al. filed. VIDED.
Dec 18 2003	Brief amicus curiae of Association of Federal Health Organizations filed. VIDED.
Dec 18 2003	Brief amicus curiae of Chamber of Commerce of the United States filed. VIDED.
Dec 31 2003	Application (03A565) for leave to file a consolidated brief on the merits in excess of the

page limitation filed by respondents, submitted to Justice Scalia. (VIDED)

Jan 7 2004 Application (03A565) granted by Justice Scalia for leave to file a consolidated brief on the merits in excess of the page limitation filed by respondents.

Jan 12 2004 SET FOR ARGUMENT Tuesday, March 23, 2004.

Jan 20 2004 Brief amicus curiae of American College of Legal Medicine filed. VIDED. (Distributed)

Jan 21 2004 CIRCULATED.

Jan 21 2004 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed. VIDED.

Jan 22 2004 Brief amicus curiae of United Policyholders filed. VIDED. (Distributed).

Jan 22 2004 Brief of respondent Juan Davila filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of Families USA, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of American Medical Association, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of Texas, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amicus curiae of Health Administration Responsibility Project filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of Community Rights Counsel, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of AARP, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amicus curiae of Association of Trial Lawyers of America filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of Edward M. Kennedy, et al. filed. VIDED. (Distributed)

Jan 22 2004 Brief amicus curiae of National Alliance for Model State Drug Laws filed. VIDED. (Distributed)

Jan 22 2004 Brief amici curiae of California Consumer Health Care Council, et al. filed. (Distributed) VIDED.

Jan 22 2004 Brief amici curiae of Council of State Governments, et al. filed. (distributed)

Feb 2 2004 Motion of Texas, et al. for leave to participate in oral argument as amici curiae and for divided argument filed (VIDED).

Feb 4 2004 Record received from the U.S.C.A. for the 5th Circuit. (1 box)

Feb 12 2004 Record received from the U.S.D.C. for Northern District of Texas. (1 box)

Feb 23 2004 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.

Feb 23 2004 Motion of Texas, et al. (VIDED) for leave to participate in oral argument as amici curiae and for divided argument GRANTED.

Feb 26 2004 Reply of petitioner Aetna Health Inc. filed. (Distributed)

Mar 12 2004 Letter of respondents proposing a lodging.

Mar 23 2004 Argued. For petitioners: Miguel A. Estrada, Washington, D.C.; and on behalf of the United States, as amicus curiae, James A. Feldman, Assistant to the Solicitor General, Department of Justice, Washington, D.C. For respondents: George P. Young, Fort Worth, Tex.; and David C. Mattax, Assistant Attorney General, Austin, Tex. (for Texas, et al., as amici curiae.)

02-1845 & 03-83 t/w 02-1826

02-1826

Petition dismissed per rule 46 of the Supreme Court

September 18, 2003

Briefs not filmed

Supreme Court, U.S.
FILED

(1)

021845 JUN 20 2003

No.

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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228 pp

QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), as construed by this Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny, completely preempts state-law claims by ERISA plan participants or beneficiaries who assert that a managed care company tortiously "failed to cover" (*i.e.*, pay for) medical care.

PARTIES TO THE PROCEEDINGS

Petitioner Aetna Health Inc. is the successor to Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., both of which merged into Aetna Health Inc. In addition to the parties named in the caption, the following individuals and entities were parties in the consolidated cases below and are respondents in this Court. The following parties were plaintiffs-appellants below: Robert Roark; Robert Roark, on behalf of the estate of Gwen Roark. The following party was a plaintiff-appellant-cross-appellee in the court below: Ruby R. Calad. The following party was a plaintiff-cross-appellee in the court below: Walter Patrick Thorn. The following parties were defendants-appellees in the court below: Humana, Inc.; Humana Health Plan of Texas, Inc., d/b/a Humana Health Plan of Texas (Dallas), d/b/a Humana Health Plan of Texas (San Antonio), d/b/a Humana Health Plan of Texas (Corpus Christi); Humana HMO Texas, Inc.; Cigna Healthcare of Texas, Inc., d/b/a Cigna Corporation.

RULE 29.6 STATEMENT

Petitioner's parent company is Aetna Inc., a publicly traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Aetna Health Inc. (as successor to Aetna U.S. Healthcare of North Texas Inc. and Aetna U.S. Healthcare Inc., which were defendants below) respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.[1]

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, at 1a-29a) is reported at 307 F.3d 298 (5th Cir. 2002). The opinion and order of the United States District Court for the Northern District of Texas denying respondent Davila's motion to remand and dismissing the complaint with prejudice (App., *infra*, at 30a-35a) is unreported.

JURISDICTION

The district court had federal question jurisdiction over the plaintiffs' claims pursuant to 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals had jurisdiction to review the final judgments of the district court pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on September 17, 2002. The court of appeals denied Aetna's petition for rehearing and suggestion for rehearing en banc on April 15, 2003. App., *infra*, at 37a-39a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). This proceeding draws into question the constitutionality of a state statute under the Supremacy Clause of the Constitution, and the notification required by this Court's Rule 29.4(c) has been transmitted to the Attorney General of Texas. Although the courts

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[1] A petition seeking review of a different aspect of the same consolidated judgment is pending as No. 02-1826.

below did not certify this issue pursuant to 28 U.S.C. § 2403(a), the Attorney General participated as *amicus curiae* in the court of appeals.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. Const. art. VI, cl. 2, and the pertinent provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), and the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003 ("THCLA"), are set forth in the Appendix, *infra*, at 41a-63a.

STATEMENT OF THE CASE

1. Petitioner Aetna Health Inc. ("Aetna") operates a federally qualified health maintenance organization ("HMO"), which provides health services to its subscribers on a prepaid basis. Aetna contracts with employers and others to administer benefits available under plans established pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

Respondent Juan Davila receives health care benefits through an ERISA plan provided by his employer, Monitronics International, Inc. Aetna insures and administers benefits for the Monitronics Plan, including precertifying, on the plan's behalf, whether coverage is available under the terms of the plan that require a particular service or prescription drug to be "medically necessary" in order to be covered. The "Certificate of Coverage" for the Monitronics Plan expressly states that "*[f]or the purpose of coverage*, HMO [Aetna] may determine whether any benefit provided under the Certificate is Medically Necessary." App., *infra*, at 122a (emphasis added; boldface omitted)). The Certificate further emphasizes, in bold print, that "**THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT**

A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE." *Id.* at 107a. In other words, under the terms of the plan Aetna decides only whether the Monitronics Plan "covers" (*i.e.*, will pay for) a proposed treatment or service, not whether a participant or beneficiary actually receives that treatment or service.

2. In April 2000, Davila visited his primary care physician, Dr. Joseph Lopez, for treatment of discomfort associated with Davila's arthritis. Dr. Lopez prescribed the painkiller "Vioxx" to alleviate that discomfort. App., *infra*, at 4a. Under the terms of Davila's benefits plan, however, participants were ordinarily required to try an analogous but less expensive medication before Aetna could authorize payment for Vioxx. *Id.* at 4a-5a. On May 10, 2000, Aetna issued a benefits determination that so advised Dr. Lopez. Aetna's letter noted that as part of its "utilization review program," Davila's "benefit design require[d] precertification for" Vioxx. The letter also outlined the circumstances in which such precertification would be granted—none of which was then applicable to Davila. *Id.* at 80a.[2] "Based on the review of information submitted to us," the letter stated, "your request to authorize payment for the Formulary excluded medication has been denied." *Id.*

Aetna's benefits determination further noted that if Dr. Lopez or Davila wished "to take exception to this decision," either could "file a formal grievance with the HMO." App., *infra*, at 81a. The letter went on to advise Dr. Lopez of his statutory "right to review by an Independent Review Organi-

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[2] The letter specified that contraindication of other medications would have been a ground for precertification. App., *infra*, at 80a. There is neither allegation nor evidence in the record that Davila's physician asserted this ground.

zation (IRO) of adverse coverage determinations based on medical necessity," including the right to expedited IRO review if Davila's condition was life-threatening. *Id.* *See generally Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (discussing interaction between state laws providing IRO rights and ERISA).

Davila and Dr. Lopez did not exercise any of the remedies outlined in Aetna's benefits determination. Nor did Davila seek relief under Section 502 of ERISA, which entitles an ERISA plan participant or beneficiary to bring an action "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Instead, Davila began taking a different medication covered by Monitronics' ERISA plan. Several weeks later, Davila was diagnosed with bleeding ulcers, which required in-patient hospital care. App., *infra*, at 5a. Davila contended that this condition was caused by Aetna's determination that Davila's plan did not immediately cover a more expensive painkiller with a lower level of gastrointestinal toxicity. *Id.* at 4a-5a, 68a-69a.

3. Davila sued Aetna (then known as Aetna U.S. Healthcare of North Texas Inc. and its corporate parent Aetna U.S. Healthcare Inc.) in Texas state court under the Texas Health Care Liability Act ("THCLA"), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003. App., *infra*, at 68a-71a. Davila sought compensatory and punitive damages, alleging that Aetna had created a likelihood of substandard care by using a formulary (a list of prescription drugs) with progressive steps of drug coverage, and had acted negligently in its decision not to cover Vioxx from the beginning. *Id.* at 5a, 31a, 70a. The complaint averred that, despite Dr. Lopez's recommendations, petitioner "refused to provide Vioxx" (*id.* at 65a), and that accordingly it "failed to use ordinary care in influencing, controlling, participating in and making healthcare treatment decisions regarding [him] through its adherence to its prescription drug formulary policies." *Id.* at 68a-69a. With his complaint, Davila submitted an affidavit from Dr. Lopez, copies of medical studies concerning Vioxx's gastrointestinal toxicity, and a copy of Aetna's letter denying precertification for Vioxx.

Aetna removed the action to the U.S. District Court for the Northern District of Texas, asserting that Davila's claims are completely preempted by ERISA and thus removable under *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). App., *infra*, at 30a-31a, 82a-91a. Davila moved to remand, alleging a lack of subject matter jurisdiction. The district court held that under *Metropolitan Life*, Davila's claims must be recharacterized as stating federal questions under ERISA:

> What Plaintiff really challenges * * * is Defendants' determination regarding which particular drugs are covered under the plan and the circumstances of that coverage. The Court concludes that, distilled to its essence, Plaintiff's claim against Defendants concerns the administration of benefits under the plan * * *. As a result, his state-law claim is completely preempted by ERISA, federal-question jurisdiction exists, and removal was proper.

Id. at 34a. Because Davila declined to plead a claim under ERISA, the court dismissed Davila's complaint with prejudice for failure to state a claim upon which relief could be granted. *Id.* at 34a-35a.

4. A panel of the Fifth Circuit consolidated Davila's appeal with several other removed ERISA actions, including those of respondents Calad, Roark, and Thorn, and reversed.[3]

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[3] Calad, Roark, and Thorn are deemed respondents under this Court's Rule 12.6.

App., *infra*, at 1a-29a. The court recognized that federal courts have removal jurisdiction over state-law claims that are completely preempted by ERISA. It read the rule in *Metropolitan Life, Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and related cases, however, to be "a narrow one," stating that a claim is completely preempted by ERISA only if it "duplicates * * * an ERISA § 502(a) remedy." App., *infra*, at 9a, 20a. The court of appeals declined to make any inquiry into "whether the state law conflicts with or frustrates a congressional purpose." *Id.* at 9a. Instead, it confined its analysis to whether the THCLA "duplicate[d]" any of the nine causes of action enumerated in Section 502(a), stating that only "[i]f [respondents] could have brought their claims under ERISA § 502(a)" would their claims be completely preempted. *Id.*

The court proceeded to analyze whether respondents "could have asserted a claim that falls within" any of the various subsections of Section 502(a). App., *infra*, at 10a. The court did not examine whether the cause of action or the remedy created by THCLA *supplemented* the exclusive remedial scheme set out in Section 502(a), but only whether respondents' claims under that statute "duplicate[d]" one of the rights of action in the federal scheme. *Id.* at 9a; *see id.* at 20a (stating that "essentially, the test employed for 'complete preemption'" is that "States may not *duplicate* the causes of action listed in § 502(a)" (emphasis added)).

The court of appeals determined first that the THCLA claim did not precisely duplicate a beneficiary's right of action to secure compliance with the terms of the ERISA plan. App., *infra*, at 10a. Although Section 502(a)(3) allows a beneficiary to sue "to enforce any provisions of [ERISA] or the terms of the plan," the court of appeals held that the THCLA claims did not duplicate such a claim, because the state law made available a form of *relief*—"damages claims"—that ERISA does not. *See* App., *infra*, at 10a. The

court's analysis, which rested entirely on the unavailability of damages under ERISA, was confined to a single sentence: "Section 502(a)(3) indicates equitable remedies are generally available under ERISA; it includes only those categories of relief that were typically available in equity, *not the damages claims Calad and Davila bring*." *Id.* (emphasis added) (citation and internal quotation marks omitted).

The court of appeals applied the same duplication analysis, and used a similarly formal distinction between "contract" and "tort," to conclude that the THCLA claims did not precisely overlap with Section 502(a)(1)(B). App., *infra*, at 15a-20a. The court reasoned: "Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract * * *. By contrast, Calad and Davila assert tort claims * * *." *Id.* at 16a. Because Davila was asserting a cause of action sounding in tort, the court reasoned, his action could not precisely "duplicate" a claim under Section 502(a)(1)(B). *See id.* at 16a-17a. Similarly, the court concluded that removal of respondent Roark's original complaint had been proper because that "complaint stated at least one cause of action completely preempted by § 502(a)": "Count Six of [that] original complaint alleges breach of contract." *Id.* at 22a, 23a. The court relied on this contract/tort distinction to distinguish an earlier circuit precedent—which it described as "on point," and in which the court had *upheld* removal based on complete preemption. *Id.* at 16a (citing *Dowden v. Blue Cross & Blue Shield, Inc.*, 126 F.3d 641 (5th Cir. 1997) (per curiam)); *see Dowden*, 126 F.3d at 643.[4] For the court

[4] "Like Calad and Davila," the court acknowledged, "Dowden claimed she was denied medically necessary treatment. But Dowden asserted a contract claim for contract damages; Calad and Davila assert a tort claim for tort damages. Calad and Davila are not seeking reimbursement for benefits denied them * * *." App., *infra*, at 17a.

of appeals, the distinction between contract and tort began and ended the analysis of whether respondents' claim "duplicate[d]" one under Section 502(a)(1)(B).

Having concluded that the state-law claims did not perfectly overlap with the causes of action included in Section 502(a), the court finally addressed this Court's decision in *Pilot Life* and Aetna's argument that the THCLA impermissibly supplemented Section 502(a)'s set of remedies. The Fifth Circuit conceded that "*Pilot Life* includes some expansive language that arguably support[ed]" preemption in this case. App., *infra*, at 19a. The panel concluded, however, that "the Supreme Court's most recent word on the matter, [*Rush Prudential*], indicates *Pilot Life* does not sweep so broadly." *Id.* The court reiterated that it would demand precise replication of a Section 502(a) cause of action before it would find complete preemption: under *Rush Prudential*, it concluded, the "narrow" rule of complete preemption applies only if States "duplicate the causes of action listed in ERISA § 502(a)." *Id.* at 20a.

The court also concluded that Davila's cause of action did not precisely replicate a claim that could be brought under ERISA § 502(a)(2). App., *infra*, at 12a-15a. The panel relied heavily on *Pegram v. Herdrich*, 530 U.S. 211 (2000), for the proposition that Davila could not sue his HMO under Section 502(a)(2). *See id.* at 12a-14a. In *Pegram*, this Court held that HMO patients cannot sue physician-owned HMOs for breach of fiduciary duty under Section 502(a)(2) based on it called "mixed eligibility and treatment decisions" by a treating physician. 530 U.S. at 228-31. Although the Fifth Circuit conceded that "*Pegram* did not decide the precise question before us," the court concluded nonetheless that "its holding is broad enough to apply here." App., *infra*, at 12a.

In light of its conclusion that Davila's claims did not precisely duplicate causes of action that could be brought under Sections 502(a)(3), 502(a)(2), or 502(a)(1)(B), the court

held that Davila's claims are not completely preempted and thus do not arise under federal law, as necessary to confer removal jurisdiction. The court therefore reversed the denial of Davila's remand motion. *See* App., *infra*, at 20a, 29a.

REASONS FOR GRANTING THE WRIT

By categorically exempting state tort actions from complete preemption, the Fifth Circuit's decision has created a conflict among the circuits that, if allowed to stand, will lead to the development of conflicting and overlapping state remedial schemes for ERISA benefits determinations. The decision below is in direct conflict with this Court's decision in *Pilot Life*, which unambiguously held that a tort claim that supplements the remedies provided by ERISA § 502 is indeed completely preempted, and with an unbroken string of this Court's subsequent decisions—all but one unanimous—that have consistently reaffirmed *Pilot Life*.

The Fifth Circuit, evidently influenced by this Court's analysis of "mixed" treatment and eligibility decisions in *Pegram v. Herdrich*, 530 U.S. 211 (2000), thought that *Pilot Life* can no longer be relied upon as resolving the very issue on which this Court ruled in that case: that a state tort action for damages represents an alternative enforcement scheme preempted by ERISA § 502(a). But *Pegram* was not a preemption ruling at all, as this Court itself noted (*id.* at 236-37), and this Court certainly did not so much as suggest that its analysis of the distinct issue in that case required reconsideration of *Pilot Life* and its progeny. Indeed, not only does the decision below usurp this Court's sole authority to overrule or modify its own decisions, it also diverges from the run of sister-circuit cases that recognize that the *Pilot Life* rule is alive and well. The decision below, by eliding binding precedent that is faithfully followed in a majority of other courts of appeals, has created a conflict on an important issue that is ripe for resolution by this Court.

I. The Fifth Circuit's Decision Conflicts Directly With An Unbroken Sequence Of Decisions By This Court

ERISA is a "'comprehensive and reticulated statute'" that sets out an exclusive, nationally uniform framework for regulating the administration of employee benefit plans. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)). A critical element of that finely balanced regulatory scheme is the remedial provision, ERISA § 502(a), which provides the full array of remedies that Congress deemed appropriate for plans and their participants and beneficiaries. As this Court repeatedly has held, the rights of action that Section 502(a) provides are exclusive in every way, and the harmony of the statutory scheme forecloses any effort by States either to add to or to detract from the causes of action provided by Section 502(a).

1. Sixteen years ago in *Pilot Life*, this Court first confirmed the exclusivity of Section 502(a) and the impermissibility of state attempts to supplement it. When the Pilot Life Insurance Company terminated an insured's disability benefits purportedly guaranteed under an ERISA plan, the insured filed suit not under ERISA § 502(a), but under Mississippi tort law. 481 U.S. at 43. As in this case, the plaintiff contended that the insurer's benefits decision failed to comport with a state standard of reasonableness and gave rise to liability for the tort of "bad faith." *See id.* at 43, 49-50. And as in this case, the Fifth Circuit held that his tort action was not preempted by ERISA. *See id.* at 44.

This Court unanimously reversed, rejecting the plaintiff's argument that his cause of action for bad faith was saved from preemption by ERISA § 514(b)(2)(A) as a permissible regulation of insurance. The Court reached that conclusion by examining the entire ERISA statutory framework and the role that Section 502(a)'s carefully enumerated remedies play within it. 481 U.S. at 51-52. As the Court

recognized, the structural integrity of ERISA depends upon the exclusivity of Section 502(a)'s enforcement remedies:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. at 54 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (alteration and emphasis in original). The Mississippi common law action for bad faith—which, for example, permits recovery of punitive damages where ERISA does not—would have upset this balance if applied to a benefits decision under ERISA. *See id.* at 50, 54. With this factor weighing heavily, the Court held the tort claim preempted. *Id.* at 57.

That same day, in another unanimous decision, *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), this Court held that Section 502(a)'s preemptive power is sufficient to confer federal jurisdiction over all claims within its ambit, including claims pleaded exclusively under state law. Taylor asserted that he was disabled, and when his disability insurer denied his claims for benefits, he sued in state court, asserting contract and tort claims under Michigan law. The defendants removed the action to federal court, where they

prevailed on the merits. The court of appeals ordered a remand to state court on the ground that the suit presented no federal question. *Id.* at 61-62. This Court unanimously reversed that holding. *Pilot Life* had established that "a suit by a beneficiary to recover benefits from a covered plan" necessarily "falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63 (citing *Pilot Life*, 481 U.S. at 56). Taylor had sought an award of benefits *and* damages arising from their denial; ERISA therefore plainly preempted his Michigan law claims under *Pilot Life*. *Id.*

Moreover, this Court held, *Pilot Life* preemption was sufficient to confer removal jurisdiction. Section 502(a) preempts so completely and so strongly that it sweeps into federal court any action within its ambit; because it has displaced any parallel state cause of action, any suit touching the same subject matter becomes a Section 502(a) claim. Taylor's complaint had pleaded only state-law causes of action; the Court held, however, that because those claims were within the scope of Section 502(a), they were "necessarily federal in character" and sufficient to invoke federal "arising under" jurisdiction. *Metropolitan Life*, 481 U.S. at 67.

Taken together, *Pilot Life* and *Metropolitan Life* unambiguously refute both the "duplication" analysis and the contract/tort distinction on which the Fifth Circuit sought to rest its holding in this case. Both decisions confirm that *all supplemental state remedies* for allegedly improper benefits administration—not just "duplicative" ones, and certainly not just those that are styled "contract" remedies or seek equitable relief—alter the balance that Congress established in Section 502(a).

First, these decisions spell out that Section 502(a) *as a whole* has preemptive force, independent of any of its individual causes of action, because Congress intended it to be exclusive. *Metropolitan Life*, 481 U.S. at 63; *Pilot Life*, 481

U.S. at 57. Allowing States to add to or vary Section 502(a)'s careful balance conflicts with that congressional purpose. *Pilot Life*, 481 U.S. at 54. The court of appeals disregarded this aspect of *Pilot Life* and *Metropolitan Life*, *see* App., *infra*, at 9a (stating that "[w]e do not ask whether the state law conflicts with or frustrates a federal purpose"), and instead focused only on duplication of the individual causes of action. The basis for the preemption holding of *Pilot Life* and *Metropolitan Life*, however, was the exclusivity of Section 502(a) *as a whole*.

Second, by their very facts, both decisions make crystal clear that state-law tort claims enjoy no exemption from complete preemption under Section 502(a). In *both cases*, the Court unanimously held that ERISA completely preempted *state-law tort claims*. *Pilot Life*, 481 U.S. at 48-49 (discussing the Mississippi tort of bad faith), *see Metropolitan Life*, 481 U.S. at 61-62. Indeed, here as in *Pilot Life*, tort actions seek to import state-law standards of reasonableness and adequacy into a benefits adjudication. *See, e.g., Pilot Life*, 481 U.S. at 49-50 (citing Mississippi cases that demonstrate that the bad faith tort applies when the failure to perform on a contract is done without a reasonable basis); App., *infra*, at 17a (noting Davila's reliance on the Texas standard of "'ordinary care'"). It was precisely this importation of individual States' common law of reasonableness into the employee benefits context, where uniformity is paramount, that *Pilot Life* forbade. *Pilot Life*, 481 U.S. at 56 ("The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws."). The rule announced in the decision below—categorically immunizing tort claims from complete preemption—cannot coexist with the holding of either *Pilot Life* or *Metropolitan Life*.

Finally, these decisions confirm the inappropriateness of the Fifth Circuit's focus on the *form of relief* available under a state cause of action as a basis for holding the state claim not "duplicative" and therefore not preempted. In particular, *Pilot Life* expressly rejected the notion that Congress could have left ERISA participants and beneficiaries "free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. Indeed, drawing on the analogous context of the Labor-Management Relations Act, which also gives rise to complete preemption, *Pilot Life* noted that Congress used the LMRA as a model for ERISA knowing full well "that the powerful pre-emptive force of § 301 of the LMRA displaced all state actions for violation of contracts between an employer and a labor organization, *even when the state action purported to authorize a remedy unavailable under the federal provision*." *Id.* at 55 (emphasis added). By focusing on the availability of *damages* under the THCLA, the Fifth Circuit directly undercut this core holding.

2. This Court has never departed from—and indeed has repeatedly reaffirmed—the analysis it adopted in *Pilot Life* and *Metropolitan Life*. For example, three years after those decisions, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the plaintiff alleged that he had been terminated to prevent his pension benefits from vesting. He filed suit in Texas state court, alleging that his employer had tortiously violated the state-law duty of good faith and fair dealing, as well as claims for wrongful discharge and breach of contract. *McClendon v. Ingersoll-Rand Co.*, 779 S.W.2d 69, 69-70 & n.1 (Tex. 1989). The Texas Supreme Court allowed his action to go forward, noting that he was seeking compensatory and punitive damages rather than the recovery of pension benefits that ERISA would have permitted him. *Id.* at 71 n.3.

As in *Pilot Life* and *Metropolitan Life*, this Court unanimously concluded that the state-law claims were completely preempted by Section 502(a)'s exclusivity. *Ingersoll-Rand*,

498 U.S. at 144-45. Because the plaintiff's right to benefits was guaranteed by ERISA, this Court concluded that his exclusive avenue of redress was Section 502. *Id.* at 145. That the plaintiff had claimed to be seeking relief in tort and contract damages, rather than in the equitable recovery of pension benefits that ERISA affords, did not matter, the Court held; the conflict was with the exclusivity of the ERISA causes of action. *Id.*

Ingersoll-Rand compellingly reinforces the conclusion that the decision below cannot be reconciled with this Court's precedents. For example, the court of appeals reasoned that "[b]ecause the THCLA does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*." App., *infra*, at 20a. Virtually identical reasoning had been adopted by the Texas Supreme Court in *Ingersoll-Rand*. That court had reasoned that complete preemption did not apply because the plaintiff "was '*not* seeking lost * * * *benefits* but [was] instead seeking lost future wages, mental anguish and punitive damages * * *.'" *Ingersoll-Rand*, 498 U.S. at 136 (quoting *McClendon*, 779 S.W.2d at 71 n.3) (emphases and second alteration in original). This Court squarely disagreed, holding that "there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek * * * 'benefits.'" 498 U.S. at 145. As this Court put it, "it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of * * * benefits." *Id.*

The Fifth Circuit gave only the most cursory attention to *Ingersoll-Rand*: The court merely stated in passing that this Court's most recent decision under ERISA § 502(a)—*Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)—had "explained" that *Ingersoll-Rand* simply applied a "duplication" test. *See* App., *infra*, at 19a-20a. But even the language that the Fifth Circuit quoted from *Rush Prudential* to support that assertion made clear that any state law that *adds* remedies such as money damages, or any law that provides a

state (rather than federal forum) for benefit disputes, is preempted (*id.* at 19a-20a)—precisely the rule that the Fifth Circuit disregarded in this case.[5]

Directly contrary to the Fifth Circuit's reading, this Court's decision in *Rush Prudential* expressly adhered to and reaffirmed the teaching of *Pilot Life*. *Rush Prudential* considered a claim by a plaintiff who had sought coverage from her HMO for an "unconventional treatment." 536 U.S. at 360. When the HMO denied coverage and instead proposed to cover a more standard treatment, the plaintiff sued in state court to demand an independent medical review, as guaranteed by a state statute, and payment for the unconventional procedure. The Seventh Circuit held that the case was properly removed to federal court, because this Court's precedents required that the state suit be recharacterized as an action under ERISA § 502(a). *See Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 967 (7th Cir. 2000), *aff'd*, 536 U.S. 355 (2002). The Seventh Circuit ruled, however, that the state statute requiring an independent medical review was not preempted, and could be enforced *in federal court only* in an action under ERISA § 502(a).

[5] In the language from *Rush Prudential* on which the Fifth Circuit relied, this Court explained that the state law at issue in *Ingersoll-Rand* had "'duplicated the elements of a claim available under ERISA'" because "'it converted the remedy from an equitable one under § [502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal).'" App., *infra*, at 19a-20a (quoting *Rush Prudential*, 536 U.S. at 379). That passage makes clear that this Court was not using "duplication" in the narrow sense adopted by the Fifth Circuit—*i.e.*, permitting preemption only of state claims that replicate the contractual-type remedies provided by ERISA. Not surprisingly, the Court in *Rush Prudential* took particular pains to reaffirm *Ingersoll-Rand*, which most directly illustrates the conflict between the decision below and this Court's cases. *Rush Prudential*, 536 U.S. at 379, 380 (observing that the Texas law invalidated in *Ingersoll-Rand* had "patently violate[d]" the uniformity mandated by Section 502(a) and "exemplified" the "sort of additional claim or remedy" that ERISA completely preempts).

In affirming that conclusion, this Court agreed that "medical necessity" determinations of the type at issue here are ERISA benefit determinations. See *Rush Prudential*, 536 U.S. at 361, 365 (stating that the Illinois law allowing independent review of "medical necessity" determinations added "an extra layer of review for certain benefit denials"). In fact, all nine Members of the Court agreed that if the independent review statute had created an additional *claim* or an additional *remedy*, it would have been preempted under *Pilot Life* and its progeny. *See id.* at 379-80 ("[T]he state statute does not enlarge the claim for benefits beyond the benefits available in any action brought under § [502(a)]. And * * * the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § [502(a)]. This case therefore does not involve the sort of additional claim or remedy exemplified in *Pilot Life*, [*Metropolitan Life*], and *Ingersoll-Rand* * * *." (footnote omitted)); *id.* at 388 (Thomas, J., dissenting) (citing *Pilot Life* for the proposition that, "as the Court concedes," a state-law claim is preempted "if it supplements the remedies provided by ERISA"). *Rush Prudential* turned not on any disagreement over the vitality of *Pilot Life*'s prohibition on benefits adjudications that supplement Section 502(a), but on the majority's determination that the independent review provision was sufficiently different from arbitration or adjudication that it *was not* an alternative means of determining entitlement to benefits that would be forbidden under *Pilot Life*. *See id.* at 381-82. And notably, *no* Member of this Court questioned the Seventh Circuit's holding that the case was properly removed from the state courts.

3. Most recently, in *Beneficial National Bank v. Anderson*, 123 S. Ct. 2058 (2003), the Court once again endorsed the principle of *Metropolitan Life*. Explaining that the principle of complete preemption applies *whenever* Congress creates an exclusively federal right of action, the Court held that claims for usury necessarily arise under the National Bank Act and are removable to federal court. *Id.* at 2063-64. Although the plaintiff pleaded state law usury claims that apparently could not survive on their merits once recharacterized as federal (*see id.* at 2063), the Court nonetheless upheld removal. And the Court took pains to reaffirm its adherence to the rule announced in *Metropolitan Life*—and on this point, it was once again unanimous. *See id.* at 2062-63, 2064 (opinion for the Court); *id.* at 2067 n.1 (Scalia, J., dissenting).

Beneficial confirms that the panel below erred in focusing so narrowly on whether a state cause of action "duplicates," in some ill-defined but narrow sense, a federal one. Confining the inquiry to duplication would rob the "complete preemption" doctrine of all of its force. Completely preemptive federal statutes "supersede both the substantive and the remedial provisions" of state law. *Beneficial*, 123 S. Ct. at 2064. The essence of the complete preemption doctrine is that states may not create a path around the exclusively federal *remedial* scheme simply by inventing a cause of action whose elements bear some substantive difference from the federal law—but which still regulates the same subject matter. Yet the approach taken by the Fifth Circuit in this case would allow States to create a path around the exclusively federal remedial scheme without even creating a substantive difference at all, but simply by *allowing a different remedy*. *See* App., *infra*, at 10a (holding that Section 502(a)(3) did not preempt the THCLA claims because it allows only equitable relief, "not the damages claims Calad and Davila bring"). *Beneficial* confirms that the key question is not how the state-law claim is articulated, but whether the conduct it challenges

is the subject of such an exclusively federal remedial scheme. Here, the challenged conduct—coverage pre-approval—clearly is a benefits-administration decision, subject to the exclusively federal remedial scheme of Section 502(a).

From *Pilot Life* through *Rush Prudential* and now *Beneficial*, the Court's decisions have consistently adhered to a set of three principles. First, ERISA's remedial provisions are exclusive; because Congress carefully weighed which rights of action to include and which to omit, any right of action *not* included must be deemed to have been *excluded*. *Pilot Life*, 481 U.S. at 54; *see Rush Prudential*, 536 U.S. at 378-79; *Ingersoll-Rand*, 498 U.S. at 144-45. Second, the policy choice embodied in Section 502(a)'s balanced set of remedies is binding on the States, which may not add to, subtract from, vary, or replicate any of these rights of action. Attempts to add a supplementary right of action are preempted. *Rush Prudential*, 536 U.S. at 379-80; *Pilot Life*, 481 U.S. at 56. Third, the complete preemption of a state cause of action turns not on the manner in which it is pleaded (tort, contract, or otherwise) or on the relief it seeks (at law or in equity), but on whether it interferes with the administration of benefits under an ERISA plan. *Pilot Life*, 481 U.S. at 51-52. Because the Fifth Circuit's decision runs directly contrary to each and every one of these principles, review by this Court is warranted to correct the Fifth Circuit's plain departure from this Court's precedents.

II. Other Federal Courts Have Continued To Apply *Pilot Life*'s Holding That Alternative Enforcement Mechanisms Are Completely Preempted

As the majority of courts of appeals have recognized, *Pilot Life* and *Metropolitan Life* foreclosed ERISA plan participants from invoking or inventing alternative state-law claims for denial of benefits by mere artful pleading. Further, those courts of appeals have adhered to those precedents without—as did the court below—reading into this Court's

more recent cases an intent to retreat from the complete preemption doctrine.

1. In *Marks v. Watters*, 322 F.3d 316, 327 (4th Cir. 2003), for example, the Fourth Circuit reaffirmed that plaintiffs may not circumvent Section 502(a)'s exclusivity by bringing state-law claims relating to benefits administration—however cleverly those claims might be characterized. *Marks* arose when an ERISA plan beneficiary checked out of the mental hospital where his insurer had approved psychiatric care, and then killed his family and himself. *Id.* at 320-21. The decedents' estates sued the insurer, alleging medical malpractice, negligence, and other state-law claims. *Id.* at 318. They contended that the plan administrator had committed negligence by causing the hospital to discharge the patient prematurely, or by referring him (allegedly based on cost) to a less desirable facility. *Id.* at 327. They argued, as did the Fifth Circuit in this case, that ERISA does not preempt state-law claims based on insurers' mixed decisions of plan administration and patient treatment—a category drawn from this Court's opinion in *Pegram*. *See id.* at 318, 322.

The Fourth Circuit rejected the contention that mixed eligibility and treatment decisions are categorically exempt from Section 502(a)(1)'s exclusive remedial provision. Preemption is determined by the substance of the claim, the court wrote, and the plaintiffs' claims were at their core claims about benefits administration. The court elaborated:

> Claims challenging the administration of an employee welfare benefit plan fall squarely within the scope of § 502(a) of ERISA. Such claims include allegations that a plan benefit was denied based on noncompliance with the terms of a plan or allegations that an ERISA fiduciary breached a duty to a plaintiff by improperly denying a benefit based solely on financial motivations. The core allegation underlying a § 502(a) claim is that a plan participant

> or beneficiary was denied a benefit to which the participant or beneficiary was entitled under an ERISA plan or that *the manner of administering the benefits caused the participants or beneficiaries some injury*. These are precisely the types of claims that plaintiffs are making * * * .

Marks, 322 F.3d at 326 (emphasis added). Thus, the *Marks* plaintiffs, like Davila, sought to engraft a state law duty of care—enforceable through money damages—onto the administration of an ERISA plan. Yet confronted with comparable facts, the Fourth Circuit reached precisely the opposite result.

Similarly, in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), the Third Circuit made clear that Section 502(a) provides the sole means of challenging "core managed care practices," even when, as here, those practices consist of allegedly "mixed" decisions that rely on medical judgments as predicates for a coverage decision. *Id.* at 274-75. The plaintiff in *Pryzbowski* sought to challenge her insurer's delay in pre-approving a surgical procedure, a delay that resulted from the HMO's preference for the use of in-network specialists. *Id.* at 273. She asserted claims sounding in tort, including negligence and bad faith. *Id.* at 270. The Third Circuit noted that the plaintiff's claim fell somewhere in between a claim challenging only a benefits determination, such as a refusal to approve services not covered by the plan, and one challenging the quality of medical care by a treating physician. *Id.* at 273. The court noted, however, that the insurer (like Aetna) did not itself provide the medical services, and that notwithstanding the medical component to its coverage decisions, those decisions necessarily fell "squarely within administrative function." *Id.* at 274. Thus, although the damages the plaintiff sought were not available under Section 502, that provision represented her exclusive means

of challenging a decision relating to benefit administration. *See id.* at 273-75.

In *Hotz v. Blue Cross & Blue Shield of Massachusetts, Inc.*, 292 F.3d 57 (1st Cir. 2002), the First Circuit also recently reaffirmed that an attack on a pre-approval decision is completely preempted, irrespective of how the claim is characterized. The plaintiff in *Hotz* brought suit under a state unfair-claim-settlement statute to challenge her insurer's allegedly unreasonable delay in the approval of a recommended procedure—a delay that allegedly caused the plaintiff's cancer to worsen. *Id.* at 58. The court reexamined and adhered to its prior precedent, which had held that state-law tort claims challenging a utilization review decision are completely preempted by ERISA. *Id.* at 60 (citing *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999)). The critical inquiry, the *Hotz* court held, is whether the claim "challenged 'the process used to assess a participant's claim for a benefit payment under the plan.'" *Id.* (quoting *Danca*, 185 F.3d at 6). Such claims—including claims sounding in tort for money damages—fall "within the ambit" of ERISA's exclusive remedial provision and are completely preempted. *Id.*; *see id.* at 58 n.1 (describing the cause of action for damages and attorney's fees). Despite any alleged "shift of emphasis by the Supreme Court," the First Circuit held, *id.* at 61 (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999)), a state action for damages and attorney's fees was precisely within the scope of the *Pilot Life* rule and thus completely preempted. *Id.*

Notably, *Hotz* significantly postdated this Court's decision in *Pegram*, on which the Fifth Circuit based its distinction of this Court's complete preemption cases. Yet the *Hotz* court was not distracted, as was the court below, by *Pegram*'s elaboration—outside the preemption context—of the distinction among treatment decisions, eligibility decisions, and mixed decisions by treating physicians. In the case on

which the *Hotz* court principally relied, the First Circuit had previously anticipated the development of that taxonomy and dismissed it as irrelevant to the scope of complete preemption under ERISA. Considering state-law tort claims brought against an insurer for routing a mental patient to a less expensive and allegedly inferior hospital, the First Circuit "recognize[d] that the allegedly negligent decisionmaking and consultation at issue [might] be characterized as medical in nature," but held that "this fact alone d[id] not remove the state causes of actions [*sic*] from the scope of § 502(a)." *Danca*, 185 F.3d at 5-6. Rather, the conduct at issue, which the court termed "quasi-medical," fell squarely within the scope of the *Pilot Life* preemption doctrine. *Id.* at 6. Thus, unlike the court below, the *Danca* court recognized that a plaintiff cannot circumvent the limitations of Section 502(a) merely by characterizing a claim for benefits as a "mixed decision."

Like *Pryzbowski*—which the First Circuit cited with approval, *see Hotz*, 292 F.3d at 60—*Hotz* cannot be reconciled with the decision below. The *Hotz* court correctly deemed the central inquiry in the preemption analysis to be whether the claim "challenged 'the process used to assess a participant's claim for a benefit payment under the plan.'" *Id.* (quoting *Danca*, 185 F.3d at 6). Davila's claim falls squarely within that category, as he alleges injury arising out of the use of the "step plan" to evaluate and pre-approve claims for prescription drug coverage. Yet the Fifth Circuit's incorrect analysis led it to reach a holding inconsistent with those of its sister circuits.

On similar facts, the Eighth Circuit has also consistently held that decisions about the levels of care that will be authorized under an ERISA plan are benefits administration questions, even though they may contain an element of medical judgment. Indeed, the Eighth Circuit "has expressly declined invitations to either expand or contract the *Pilot Life*

doctrine that ERISA's civil enforcement remedies preempt conflicting or competing state law judicial remedies," *Fink v. Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003), and has consistently held that all attempts to plead medical malpractice, breach of fiduciary duty, or similar tort claims to challenge "mixed" coverage and treatment decisions are completely preempted by ERISA.

The Eighth Circuit's decision in *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam), is emblematic. Just as Davila alleged negligence stemming from the refusal to prescribe a more suitable, less toxic anti-arthritis drug at the outset of treatment, so Thompson alleged malpractice from the refusal to authorize a more suitable, more aggressive course of treatment. The Eighth Circuit rejected the plaintiff's contention that ERISA leaves room for state-law tort regulation, and it noted that the "patient and her treating physicians retained the ultimate decision-making authority regarding her medical care. If she disagreed with Gencare's pre-certification decisions, ERISA afforded her a timely equitable remedy to review Gencare's interpretation of the plan, a remedy she did not pursue." *Id.* at 1074. And that remedy remains exclusive under the *Pilot Life* line of cases. *Id.* at 1073. Numerous other cases in the Eighth Circuit stand for the same proposition. *See, e.g.*, *Howard v. Coventry Health Care, of Iowa, Inc.*, 293 F.3d 442, 446 (8th Cir. 2002) (per curiam); *Hull v. Fallon*, 188 F.3d 939, 942-43 (8th Cir. 1999) (holding completely preempted a medical malpractice claim against a health plan administrator who allegedly made an improper determination that a thallium stress test was not "medically necessary" under the plan's definition); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 438-40 (8th Cir. 1997) (holding completely preempted a breach of fiduciary duty claim against a plan whose administrator refused to precertify experimental cancer coverage).

Rounding out the circuits adhering to the majority view, the Tenth Circuit likewise has rejected the notion that subsequent authority has undermined *Pilot Life* or its progeny so as to permit plan beneficiaries to sue in tort. In a recent decision, that court adhered to its prior precedent holding that a state tort action for bad faith was an impermissible attempt to obtain remedies precluded by Section 502(a), and therefore ruled that such an action was completely preempted. *Conover v. Aetna U.S. Healthcare, Inc.*, 320 F.3d 1076, 1079-80 (10th Cir. 2003) (citing *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997)); *see also Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1272-75 (10th Cir. 1996) (holding completely preempted a claim against a managed care company for allegedly negligent "refus[al] to authorize" medical treatment). Indeed, quite unlike the court below, the Tenth Circuit observed that this Court's *Rush Prudential* opinion had "*reaffirmed* this portion of the *Pilot Life* decision." *Conover*, 320 F.3d at 1078 n.2 (emphasis added).[6]

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[6] While several courts of appeals—unlike the decision below—have expressly reaffirmed the vitality of *Pilot Life* since this Court's decision in *Pegram*, the decisions applying *Pilot Life* in analogous circumstances before *Pegram* are legion. In *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996), for example, the plaintiff's heath insurer approved only a knee replacement, without the associated physical therapy. Jass underwent the therapy but did not undergo rehabilitation; she promptly sued in state court asserting that the insurer's negligence caused the resulting scarring. Although there was certainly a medical aspect to the decision not to approve the therapy, the claim against the HMO was "in effect a claim for denial of benefits." *Id.* at 1489. The court accordingly held that the claim was completely preempted. *Accord Parrino v. FHP, Inc.*, 146 F.3d 699, 702-03 (9th Cir. 1998); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 940-41 (6th Cir. 1995).

2. Although the weight of circuit authority continues to hold that Section 502(a) completely preempts participants' and beneficiaries' attempts to challenge benefits determinations by bringing tort actions, the instant case is not the only decision that diverges from the majority rule on this point. In an opinion rendered after the decision below, the Second Circuit broadened the circuit split that this case presents by substantially agreeing with the Fifth Circuit. In *Cicio v. Doe*, 321 F.3d 83 (2d Cir. 2003), as in this case, the Second Circuit considered an HMO's decision to approve a treatment less elaborate than the course sought by the patient and his treating physician. *See id.* at 88. The plaintiff and his physician sought a double stem-cell transplant to treat the patient's multiple myeloma; the patient's HMO refused to pay for the double transplant, as an "experimental/investigational" treatment that was not covered by the plaintiff's plan. *Id.* (The HMO offered a less expensive alternative.) Upholding state-law claims for medical malpractice, *id.* at 90, a divided panel of the Second Circuit held that although the HMO's conduct involved an aspect of benefits administration, the simultaneous presence of a medical component subjected the HMO's decision to regulation under state law. *See id.* at 103.

Expressly disagreeing with the Third Circuit, *see id.* (rejecting *Pryzbowski*, 245 F.3d at 279), and following the same course as the court below, *Cicio* relied on the "mixed eligibility and treatment decision" formulation from *Pegram* and held that state claims challenging such decisions are not preempted by ERISA. *Id.* at 104. The court also stated that "nothing in ERISA suggests that Congress intended any displacement of 'the quintessentially state-law standards of reasonable medical care.'" *Id.* at 103 (quoting *Rush Prudential*, 536 U.S. at 387). This assertion is precisely contrary to *Ingersoll-Rand* (a decision that, as noted, the *Rush Prudential* Court took pains to approve), which teaches that the comprehensiveness of ERISA's *remedial* provision points to just such a displacement by Section 502(a). *Ingersoll-Rand*, 498

U.S. at 144 ("It is clear to us that the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrant[s] pre-emption in this case." (alteration in original; internal quotation marks omitted)). Thus, the Second Circuit has exacerbated the circuit split over the current vitality of *Pilot Life* and its progeny.

Dissenting in *Cicio*, Judge Calabresi pointed out a number of analytical errors that recur both in the majority opinion in *Cicio* and in the Fifth Circuit decision in this case. For Judge Calabresi, it was not even necessary to decide whether *Rush Prudential* had somehow narrowed the scope of *Pilot Life*. *See Cicio*, 321 F.3d at 108 & n.2 (Calabresi, J., dissenting in part). Because the insurer's challenged decision was plainly one of coverage, even if it could be viewed as incorporating aspects of "medical judgment," it was plainly preempted. *Id.* at 108-09. Noting that "*Pegram*, of course, was not a preemption decision," Judge Calabresi also pointed out that "coverage decisions * * * can be made for any number of reasons, medical and non-medical." *Id.* at 109 & n.4. "Even accepting [a] more limited * * * scope of preemption," Judge Calabresi explained that the analysis was unchanged:

> The answer lies in whether the suit, in its essence, is to obtain relief for the violation of rights under the terms of the ERISA plan, in which case the state action is preempted, or whether it is a suit for malpractice *against a doctor* (or the doctor's employer) as to which the existence of ERISA coverage is only incidental. To put it another way, if ERISA were not there, would this suit essentially be against an insurance provider for negligently failing to give the coverage contracted for, or would the suit be against a medical care provider for negligent failure to treat? Because I think the current suit is clearly of the first sort, I regretfully conclude that it is barred.

Id. at 108 (emphasis added). Judge Calabresi correctly focused on whether "the suit, in its essence," was one based on the violation of rights under an ERISA plan, not—as did the court below—on whether the formal elements of the state-law claims are *identical* to the elements of an ERISA claim.

Although Judge Calabresi was in dissent, his analysis is consistent with that employed by a majority of the courts of appeals. The weight of authority holds that state tort claims may be preempted by ERISA, and that this Court's recent decisions countenance no retreat from this core holding of *Pilot Life* and its progeny. The decision below and the majority opinion in *Cicio* erroneously diverge from that consensus. Because the Fifth Circuit (in this case) and the Second Circuit (in *Cicio*) both have declined to reconsider the question *en banc*,[7] only this Court's intervention can restore uniformity to this important area of federal law.

III. The Circuit Split On This Issue Is Firmly Entrenched, And This Court's Review Is Warranted To Resolve A Question Of Considerable National Significance

The issue presented by this case is a significant and recurring one. Millions of Americans receive medical insurance through employer-provided health plans governed by ERISA, and many of those health plans rely on HMOs as a means of providing cost-effective care. Indeed, as this Court recognized in *Pegram*, the very reason for HMOs' existence is to maximize the cost-efficiency of the health care services provided to their members. Cost-efficiency necessarily involves the institution of cost-management policies like the one at issue in this case, which holds certain more expensive prescription medications in reserve and gives more readily

[7] *See* App., *infra*, at 36a; Order, *Cicio v. Doe*, No. 01-9248 (2d Cir. Apr. 21, 2003).

accessible medications a chance to work. *E.g.*, *Pryzbowski*, 245 F.3d at 274-75. Disputes over benefits are therefore frequent, and Congress, after extensive study and with considerable care, constructed an elaborate framework by which to ensure uniform treatment of these disputes by ERISA plans.

The decision below clearly flouts that framework, to say nothing of numerous decisions of this Court. Indeed, even if the Fifth Circuit were correct in perceiving a shift in this Court's preemption jurisprudence (and it is not), its failure to abide by *Pilot Life*, *Metropolitan Life*, and *Ingersoll-Rand* would itself be grounds for this Court's intervention. This Court has previously rebuked the Fifth Circuit for failure to accord due weight to the governing precedents of this Court, stating unambiguously:

> If a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.

Rodriguez de Quijas v. Shearson/Am. Express Inc., 490 U.S. 477, 484 (1989); *accord, e.g.*, *id.* at 486 (Stevens, J., dissenting); *State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997); *Agostini v. Felton*, 521 U.S. 203, 237 (1997). In the circumstances of this case, the Fifth Circuit's plain refusal to follow controlling authority could appropriately be remedied by summary reversal.

In any event, the issue presented by this case is ripe for this Court's intervention, whether plenary or summary. The divide among the circuits over the proper interpretation of a far-reaching federal statute—and this Court's construction of it—has sufficiently calcified that this Court's resolution of the issue is necessary. The paramount objective of ERISA is a uniform federal body of benefits law. The persistence of the blinkered approach to Section 502(a) preemption that this

case exemplifies frustrates that objective and warrants this Court's intervention.

CONCLUSION

The petition for a writ of certiorari should be granted. The Court may wish to consider summary reversal.

Respectfully submitted.

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June 20, 2003

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

Nos. 01-10831, 01-10891 and 01-10905.

[Filed Sept. 17, 2002]

ROBERT ROARK; ROBERT ROARK, ON BEHALF OF THE ESTATE OF GWEN ROARK,

Plaintiffs-Appellants,

v.

HUMANA, INC.; HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (DALLAS), DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI); HUMANA HMO TEXAS, INC.,

Defendants-Appellees.

RUBY R. CALAD,

Plaintiff-Appellant-
Cross-Appellee,

WALTER PATRICK THORN,

Plaintiff-Cross-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INCORPORATED, DOING BUSINESS AS HEALTHSOURCE, DOING BUSINESS AS CIGNA CORPORATION,

Defendant-Appellee,

AETNA U.S. HEALTHCARE; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,

Defendants-Appellees-
Cross-Appellants.

JUAN DAVILA,

Plaintiff-Appellant,

v.

AETNA U.S. HEALTHCARE, INC.; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,

Defendants-Appellees.

Before SMITH, BENAVIDES, and PARKER, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

This suit consolidates multiple district court actions and appeals for consideration of common issues. Ruby Calad, Walter Thorn, Juan Davila, and Gwen Roark sued their respective health maintenance organizations ("HMO's") for negligence under Texas state law: They alleged that although their doctors recommended treatment, the HMO's negligently refused to cover it. The HMO's removed to federal court, arguing that because each plaintiff received HMO coverage through his employer's ERISA plan, the claims arose under ERISA. The plaintiffs moved to remand.

The respective district courts denied Calad, Davila, and Roark's remand motions and dismissed their claims under FED. R. CIV. P. 12(b)(6), citing ERISA preemption. The district court granted Thorn's remand motion. Roark, Calad, and Davila appeal the refusal to remand and, in the alternative, the dismissal. Thorn's HMO appeals the remand. We affirm the judgments in Roark's and Thorn's cases and reverse with respect to Calad and Davila.

I.

A. Ruby Calad

Through her husband's employer, Calad became a member of CIGNA HealthCare of Texas, Inc. ("CIGNA"), a Texas HMO. Calad underwent a hysterectomy with rectal, bladder, and vaginal repair. The surgery was performed by a CIGNA physician. Although that doctor recommended a longer stay, CIGNA's hospital discharge nurse decided that the standard, one day hospital stay would be sufficient. Calad suffered complications that returned her to the emergency room a few days later; she attributes these complications to her early release.

Calad sued in state court under the Texas Health Care Liability Act ("THCLA"),[1] alleging CIGNA had failed to use ordinary care in making its medical necessity decisions, CIGNA's system made substandard care more likely, and CIGNA acted negligently when it made its medical necessity decisions. CIGNA removed to federal court based on ERISA preemption. Calad moved to remand, but the court denied the motion. The court noted "that Calad has repeatedly made clear that, should the Court deny her motion to remand, she will not amend her pleading to bring an ERISA claim and therefore requests that her claims be dismissed." Accordingly, the court dismissed under rule 12(b)(6).

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[1] TEX. CIV. PRAC. & REM. CODE §§ 88.001-88.003.

B. Walter Thorn

Thorn received Aetna U.S. Healthcare insurance through his employer. He injured his hand in a car accident, and doctors amputated his ring finger. The doctors said he needed surgery in two to three days, or he would lose his hand. An Aetna-designated specialist scheduled the surgery for the next day.

A few hours before the scheduled surgery, Aetna refused to authorize its surgeon to operate. While Aetna reviewed the case, it sent a physical therapist to help exercise Thorn's hand, so it would not deteriorate while Thorn waited for surgery. Aetna eventually approved the surgery, but Thorn contends that Aetna's delay caused scarring that has diminished his manual mobility.

Thorn sued jointly with Calad. Initially, Calad and Thorn alleged that CIGNA and Aetna were jointly and severally liable. They later withdrew this allegation, explaining it was a pleading error. Thus, Calad's claims run only against CIGNA, and Thorn's runs only against Aetna. CIGNA removed to federal court (with Aetna's consent), citing ERISA preemption. Thorn moved to remand, arguing that ERISA excludes government plans such as his from preemption. The district court remanded Thorn's claim.

C. Juan Davila

Davila is a post-polio patient who suffers from diabetes and arthritis. He received Aetna HMO coverage through his employer's health plan. His primary care physician prescribed Vioxx for Davila's arthritis pain. Studies have shown that Vioxx has a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do the other drugs on Aetna's formulary. Before filling the prescription, Aetna required Davila to enter its "step program": Davila first would have to try two different medications; only if he suffered a detrimental reaction to

the medications or failed to improve would Aetna evaluate him for Vioxx use.

As part of the step program, Davila first was given naprosyn (a cheaper pain reliever). After three weeks, he was rushed to the emergency room. The doctors reported he suffered from bleeding ulcers, which caused a near heart attack and internal bleeding. The doctors gave Davila seven units of blood and kept him in critical care for five days. Now he cannot take any pain medication that is absorbed through the stomach.

Davila sued in state court under the THCLA, alleging Aetna had failed to use ordinary care in making medical necessity decisions, Aetna's systems made substandard care more likely, and Aetna acted negligently in making its medical necessity decisions. Aetna removed to federal court, citing ERISA preemption.

Davila moved to remand. The court concluded that some of Davila's claims were completely preempted under ERISA § 502(a) and thus denied remand. The court noted that normally it would dismiss Davila's state law claims and grant him leave to file an amended complaint under ERISA. But, because Davila had informed the court he would not pursue an ERISA claim, it instead dismissed with prejudice under rule 12(b)(6).

D. Gwen Roark

In 1990, Roark was bitten by what was believed to be a brown recluse spider. The bite damaged the skin, muscle, and bone of her left leg, requiring antibiotics, three skin graft operations, and two surgeries to create "free flaps" over her wound. In 1997, Roark began using a vacuum-assisted closure device ("VAC") to circulate blood to the skin's surface and quicken healing. Each day, a nurse came to Roark's home and spent two hours scraping the wound with a scalpel;

Roark wore the VAC for the other twenty-two hours of the day.

Later that year, Humana Health Plan of Texas ("Humana") became the Roarks' HMO. Roark's primary care physician recommended she continue using the VAC and authorized treatment. In 1998, Humana delayed the VAC treatments and home nursing several times; upon each delay, Roark filed an immediate appeal or grievance. The primary care physician told Humana that without the VAC and home nursing case, Roark could lose her leg. Humana eventually approved the VAC for ninety days. Humana periodically delayed VAC and home nursing treatment until December 1998, when it cancelled home nursing altogether. Humana agreed to pay only for visits to a local hospital's wound center.

In February 1999, Roark developed a serious infection that required the doctors to amputate her leg that March. While Roark was convalescing, Humana again denied her VAC treatment that may have helped heal the amputation wound. In January 2000, the doctors performed an additional amputation treatment on her leg.

Roark and her husband Robert sued in state court under the THCLA, the Texas Deceptive Trade Practices Act ("DTPA"),[2] the Texas Insurance Code,[3] and common law breach of good faith, fair dealing, and contract. Humana removed to federal court, citing ERISA preemption. The Roarks moved to remand. The court found that the Roarks' DTPA and insurance claims were completely preempted under ERISA § 502(a) and thus denied the motion.

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2 TEX. BUS. & COM. CODE § 17.46(a), (b)(5), (b)(12).

3 TEX. INS. CODE art. 21.21 §§ 4(1), (2), (11)(a), (11)(c).

The Roarks then amended their complaint to allege only violations of the THCLA—that Humana had failed to use ordinary care when it made its medical necessity decisions, Humana's system made substandard care more likely, and Humana was negligent in making its medical necessity decisions—and filed a second remand motion. The court held that ERISA § 502(a) preempts the THCLA claim as well, denied the Roarks' motion to remand, and dismissed under rule 12(b)(6).

The court gave the Roarks thirty days to replead under ERISA § 502(a), failing which their case would be dismissed with prejudice under rule 12(b)(6). The Roarks declined and filed this appeal challenging the second remand order. The district court never entered the final order dismissing the case with prejudice under rule 12(b)(6), but it did list the case closed for statistical purposes. The Roarks' notice of appeal also states that they will not replead under ERISA.

II.

A. Calad's and Davila's remand motions

With exceptions not relevant here, "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). If, before final judgment, it appears the case was not properly removed because it was not within the federal courts' original jurisdiction, the district court must remand. 28 U.S.C. § 1447(c).

The "well-pleaded complaint rule" limits federal courts' original jurisdiction to those cases in which the plaintiffs complaint states a cause of action arising under federal law; a federal defense will not do. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9-10 (1983) (citing *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149 (1908)).

"[S]ince 1887 it has been settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiffs complaint, and even if both parties admit that the defense is the only question truly at issue in the case." *Franchise Tax Bd.*, 463 U.S. at 13-14.

Calad and Davila advance only state law causes of action; a straightforward application of the well-pleaded complaint rule would deprive the federal courts of original and removal jurisdiction over their claims. But, we recognize an exception to the well-pleaded complaint rule for those few statutes whose "preemptive force . . . is so powerful as to displace entirely any state causes of action." *Id.* at 23. Where "a federal cause of action completely preempts a state cause of action, any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 24. Such actions are excepted from the well-pleaded complaint rule and confer original and removal jurisdiction. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66, (1987); *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 336 (5th Cir. 1999). The Supreme Court first recognized this exception for § 301 of the Labor-Management Relations Act ("LMRA")[4] and has extended the rule to some, but not all, cases under ERISA.[5]

ERISA provides two types of preemption: complete preemption under § 502(a) and conflict preemption under § 514. *Giles*, 172 F.3d at 336; *McClelland v. Gronwaldt*, 155 F.3d 507, 515-17 (5th Cir. 1998). "Section 502, by providing

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[4] *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968); *see also Franchise Tax Bd.*, 463 U.S. at 23.

[5] *Metropolitan Life*, 481 U.S. at 64-65.

a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief." *Id.* at 337.

Section 502(a) complete preemption is a slight misnomer, for it does not involve traditional preemption analysis. *McClelland*, 155 F.3d at 516 ("Complete preemption is less a principle of substantive preemption than it is a rule of federal jurisdiction."). We do not ask whether the state law conflicts with or frustrates a congressional purpose, but whether the state law duplicates or "falls within the scope of" an ERISA § 502(a) remedy. *Taylor*, 481 U.S. at 64; *McClelland*, 155 F.3d at 518. If Calad and Davila could have brought their claims under ERISA § 502(a), the claims would be completely preempted, and the district court would have been correct to exercise jurisdiction.

Section 514, in contrast, provides for ordinary conflict preemption.[6] State law claims that fall outside § 502(a), even though preempted by § 514, follow the well-pleaded complaint rule and do not confer original or removal jurisdiction. *Franchise Tax Bd.*, 463 U.S. at 23-27; *Giles*, 172 F.3d at 337.

We review the district court's preemption analysis, which formed the basis for its subject matter jurisdiction, *de novo*. *McClelland v. Gronwaldt*, 155 F.3d 507, 511 (5th Cir. 1998). Because we conclude that § 502(a) does not displace Calad's or Davila's claims, the district court should have remanded.

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[6] ERISA § 514(a) preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a).

The enforcement provisions listed in ERISA § 502(a)(5)-(9) do not provide a cause of action for participants and beneficiaries; because Davila is an ERISA participant[7] and Calad is an ERISA beneficiary,[8] neither could have asserted a claim that falls within these subsections.[9] Subsections 502(a)(1)(A) and (4) deal with plan administrators' duties to supply information; they too are irrelevant. Section 502(a)(3) indicates equitable remedies are generally available under ERISA; it includes only "those categories of relief that were typically available in equity," *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), not the damages claims Calad and Davila bring, *id.* at 713. This leaves only two enforcement provisions of § 502(a)[10]—§ 502(a)(2)

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7 *See* 29 U.S.C. § 1002(7) ("The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization").

8 *See* 29 U.S.C. § 1002(8) ("The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder").

9 *Cf. McClelland*, 155 F.3d at 518.

10 In its entirety, § 502(a) reads,

> (a) Persons empowered to bring a civil action
> A civil action may be brought—
> (1) by a participant or beneficiary—
> (A) for the relief provided for in subsection (c) of this section, or

[Footnote continued on next page]

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> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
> (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
> (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;
> (6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section;
> (7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);
> (8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or
> (9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the al-

[Footnote continued on next page]

and (a)(1)(b)—neither of which preempts Calad's or Davila's claims.

1. § 502(a)(2)

Calad and Davila argue that their HMO's were not acting as plan fiduciaries when denying them medical treatment, so § 502(a)(2) cannot cover (or completely preempt) their THCLA claims. We agree.

Section 502(a)(2) allows a plan participant or beneficiary to sue "for appropriate relief under section 1109 of this title." 29 U.S.C. § 1132(a)(2). Section 1109(a) in turn provides:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach

29 U.S.C. § 1109(a).

In *Pegram v. Herdrich*, 530 U.S. 211 (2000), the Court decided that under § 502(a)(2), a patient cannot hold his HMO vicariously liable for its physician's medical malpractice. Although *Pegram* did not decide the precise question before us—whether, under § 502(a)(2), a patient can hold his HMO *directly* liable for its own medical malpractice—its holding is broad enough to apply here.

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leged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. 1132(a).

In *Herdrich*, the plaintiff became a patient of Pegram's through her HMO. When Pegram discovered an inflamed mass in Herdrich's abdomen, she did not order an immediate ultrasound; instead, she decided Herdrich would have to wait eight days to be examined at a center fifty miles away; in the meantime, Herdrich's appendix ruptured.

Herdrich sued Pegram for medical malpractice and sued both Pegram and her HMO under ERISA §§ 502(a)(2) and 1109, alleging that the HMO's medical rationing scheme, by which it "reward[ed] its physician owners for limiting medical care, entailed an inherent breach of an ERISA fiduciary duty, because these terms created an incentive to make decisions in the physicians' self- interest rather than in the exclusive interest of the plan participants." *Pegram*, 530 U.S. at 216.

The Court unanimously ruled that Herdrich did not state a cause of action under § 502(a). The Court first categorized Herdrich's claim. HMO's, it explained, made three types of decisions—eligibility decisions, treatment decisions, and mixed eligibility and treatment decisions. *Id.* at 228-29. Eligibility decisions "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* at 228.

Pure eligibility decisions, "simple yes-or-no questions, like whether appendicitis is a covered condition," are likely rare. *Id.* Treatment decisions, "by contrast, are choices about how to go about diagnosing and treating a patient's condition." *Id.* Herdrich's case, the Court concluded, involved "the more common" mixed decision, such as "whether one treatment option is so superior . . . and needed so promptly, that a decision to proceed would meet the medical necessity requirement." *Id.* at 228-29. Claims regarding such "mixed eligibility and treatment decisions," the Court held, do not fall within § 502(a)(2). *Id.* at 231-32.

It seems beyond dispute that Calad's and Davila's claims involve such mixed decisions. CIGNA agrees its plan covers

hospital stays after a hysterectomy, and Aetna agrees its plan includes a range of arthritis drugs, so we are not presented with simple yes-or-no coverage questions. Instead, we are presented with the type of "when and how" medical necessity questions—whether Calad was provided enough treatment (enough days in the hospital) and whether Davila was prescribed the correct treatment (naprosyn instead of Vioxx)—that fall within *Pegram*'s rule. *Id.* at 228-29.

Pegram is distinguishable in one regard: Herdrich claimed her doctor made the erroneous medical decision; Calad and Davila claim their HMO's did. But *Pegram's* reasoning indicates this distinction is immaterial to the § 502(a)(2) analysis.

The *Pegram* Court expressed doubt that "that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231. It contrasted fiduciaries, who must "act solely in the interest of the patient without possibility of conflict," *id.* at 233, with HMO's, whose entire purpose is to balance costs against patient welfare, *id.* at 231-32. "Since inducement to ration care goes to the very point of any HMO scheme," *id.* at 221, treating HMO's as ERISA fiduciaries would entail "nothing less than the elimination of the for-profit HMO," *id.* at 233.

The *Pegram* Court went on to note the potential "mischief' the alternative holding would entail. *Id.* at 236. Such a rule would create a federal body of malpractice law applicable against HMO's and physicians. *Id.* at 235-36. And, because ERISA § 502(a) preempts any overlapping state law, this would create "a puzzling issue of preemption"; it "would seem to be a prescription for preemption of state malpractice law." *Id.* at 236. This could not be so, the Court explained, for "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose," *id.* at 237 (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v.*

Travelers Ins. Co., 514 U.S. 645, 654-55 (1995)), and it was unimaginable that Congress intended ERISA to create a federal common law of medical malpractice. *Id.*

These factors apply with equal force to a claim that an HMO breached its fiduciary duty in denying care. Such a claim demands that the HMO forego its core purpose—rationing care—and act only in the patient's interest. And, such a claim would create a federal body of malpractice law applicable against HMO's. Because *Pegram* is indistinguishable, § 502(a)(2) does not completely preempt Calad's and Davila's THCLA claims.

2. § 502(a)(1)(B)

The Supreme Court has declined to decide whether § 502(a)(1)(B) displaces a medical malpractice claim involving "mixed decisions," *Pegram*, 530 U.S. at 229 n.9, and this circuit has not yet confronted the question.[11] We now con-

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[11] In *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), we held that § 514 preempted a patient's claim that her HMO was medically negligent for refusing to hospitalize her. Section 502(a) preemption is a subset of § 514 preemption. Although any claim that falls within § 502(a) necessarily falls within § 514, claims that fall under § 514 do not necessarily fall under 502(a). *McClelland*, 155 F.3d at 517. Thus, *Corcoran* does not decide our question.

In *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir. 2000), *vacated on other grounds by Montemayor v. Corporate Health Ins.*, 122 S. Ct. 2617 (2002), we ruled that § 514 (and thus § 502(a)(1)(B)) does not preempt a THCLA suit holding an HMO vicariously liable for its doctor's negligence. But we cannot automatically extend *Corporate Health's* holding to suits directly against an HMO. The *Corporate Health* court held

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clude that § 502(a)(1)(B) does not preempt Calad's and Davila's THCLA claims.

Section 502(a)(1)(B) allows a plan participant or beneficiary to bring a civil action "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Calad's and Davila's claims of HMO medical malpractice differ fundamentally from the § 502(a)(1)(B) claims we have recognized. Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract: When a plan administrator incorrectly interprets the plan to deny benefits, the patient may sue to recover the benefits.[12] By contrast, Calad and Davila assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan.

Dowden v. Blue Cross & Blue Shield. Inc., 126 F.3d 641 (5th Cir. 1997) (per curiam), is on point. The plaintiff's health insurer refused to cover the expenses she incurred treating complications from breast implants. The insurance policy limited coverage to only "medically necessary" treatments, and the plan administrator concluded that Dowden's

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that when a doctor denies treatment, he makes a quality-of-care decision, which escapes ERISA preemption. By contrast, when an HMO denies treatment, it makes a coverage decision, and claims over such a decision are preempted by ERISA. *Id.* at 534-35 & n.24. *But cf. Pegram* 530 U.S. at 228-30 (indicating courts should look to the substance of the decision, not the identity of the decisionmaker, in determining whether ERISA applies).

12 *See, e.g., Gosselink v. Am. Tel. & Telegraph Inc.*, 272 F.3d 722, 726-28 (5th Cir. 2001); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 636 (5th Cir.), *modified*, 979 F.2d 1013 (5th Cir. 1992).

treatment did not fit the plan's definition. *Id.* at 644. Dowden sued under § 502(a)(1)(B), claiming "the plan administrator abused its discretion in interpreting the term 'medically necessary' as expressly defined in the insurance contract," and wrongfully withheld benefits owed to her. *Id.* at 643.

Superficially, this claim resembles Calad's and Davila's: Like Calad and Davila, Dowden claimed she was wrongfully denied medically necessary treatment. But, Dowden asserted a contract claim for contract damages; Calad and Davila assert a tort claim for tort damages. Calad and Davila are not seeking reimbursement for benefits denied them: Calad is not requesting the value of an extra night at the hospital, and Davila is not requesting reimbursement for the more expensive drug the HMO denied.

In deciding Dowden's claim, we were limited to the plan and its definition of "medically necessary." For Calad and Davila, the wording of their plans is immaterial; they invoke an external, statutorily imposed duty of "ordinary care."

Furthermore, this court has treated as given that ERISA provides no cause of action for medical malpractice claims against an HMO. In *Corcoran* we noted the troubling result of our holding that ERISA § 514 bars states from providing such remedies: "The result ERISA compels us to reach means that the [plaintiffs] have no remedy, state or federal, for what might have been a serious mistake."[13] Nor have we ever recognized a claim of HMO medical negligence under § 502(a)(1)(B).

The Third Circuit has reached the same conclusion. In *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir.

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13 *Corcoran*, 965 F.2d at 1338; accord *id.* at 1333; Note, *Recent Cases*, 114 HARV. L. REV. 1406, 1409 (2001).

1995), the court held that claims that an HMO had failed to exercise reasonable care in providing medical treatment are not completely preempted by § 502(a)(1)(B). The plaintiff complained that her hospital provider had acted negligently in delaying her husband's blood test. This delay led to a late diagnosis of his condition and, she argued, his untimely death. *Id.* Her HMO, she asserted, was vicariously liable for the hospital's malpractice and directly liable for negligence in selecting its medical service providers.

Such a claim, the court explained, was not completely preempted, because it "merely attacked the *quality* of benefits received." *Id.* at 356. "Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies on [her husband] because the ERISA plan refused to pay for the studies." *Id.* at 357.

The Third Circuit's more recent decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), reaffirms this conclusion. The plaintiff claimed, *inter alia*, that her HMO "'negligently and carelessly delayed in giving its approval for the necessary surgery which the plaintiff . . . urgently needed.'" *Id.* at 270 (alterations in original). Although the court held that ERISA § 502(a)(1)(B) completely preempted this claim, it grounded its holding in its finding that the claim involved "core administrative function," the type of "pure eligibility decision" as defined by *Pegram* not the type of treatment decision involved in *Dukes*. *Id.* at 274.

CIGNA and Aetna cite *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), for the proposition that Congress intended § 502(a)(1)(B)'s contract action to be the sole remedy available. They argue that patients must pay for services ahead of time and, if the plan administrator denies benefits, sue for reimbursement under § 502(a)(1)(B). Although *Pilot*

Life includes some expansive language that arguably supports CIGNA and Aetna's reading,[14] the Supreme Court's most recent word on the matter, *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002), indicates *Pilot Life* does not sweep so broadly.

In *Pilot Life*, an ERISA participant who was denied benefits sued in state court, asserting common law contract claims. The Court held § 502(a)(1)(B) preempted the claim. ERISA provides a means of collecting benefits and set forth an exclusive list of remedies; states could not create alternative causes of action for collecting benefits that expanded upon ERISA's remedies. *Pilot Life*, 481 U.S. at 54-55; *Rush Prudential*, 122 S. Ct. at 2166.

Since *Pilot Life* the Supreme Court has "found only one other state law to 'conflict' with § 502(a) in providing a prohibited alternative remedy." *Rush Prudential*, *id.* In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court held that "Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement." *Rush Prudential*, 122 S. Ct. at 2166. The *Rush Prudential* Court explained its holding in *Ingersoll-Rand*: "[The] state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for

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[14] *See, e.g.*, *Pilot Life*, 481 U.S. at 54 ("[Congress's] inclusion of certain remedies and exclusion of others . . . would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. . . . 'Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly'" (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

money damages (available in a state tribunal)." *Rush Prudential*, *id.*

We glean from *Rush Prudential* that *Pilot Life's* rule is a narrow one: States may not duplicate the causes of action listed in ERISA § 502(a). This is, essentially, the test employed for "complete preemption." Because the THCLA does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*.

Any doubts we might have are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice. *See Pegram*, 530 U.S. at 236-37. We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B). Having concluded that § 502(a) does not completely preempt Calad's and Davila's THCLA claims, we vacate and remand to the district court for proceedings consistent with this decision.

B. Thorn's motion to remand

Aetna cross-appeals the decision to remand Thorn's claims to state court. Except for those cases removed pursuant to 28 U.S.C. § 1443, "[a]n order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise." 28 U.S.C. § 1447(d). On its face, this statute seems to deprive us of jurisdiction over Aetna's cross-appeal. But we read 1447(d) in conjunction with § 1447(c)'s command that "[i]f at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded." 28 U.S.C. § 1367(c). Accordingly, 1447(d) applies only where a district court remands for lack of subject matter jurisdiction; we may review remands based on other grounds. *Things Remembered v. Petrarca*, 516 U.S. 124, 127-28 (1995); *Giles*, 172 F.3d at 336.

Reviewable remand orders are a narrow class of cases, meaning we review a remand order only if the district court "'clearly and affirmatively' relies on a non-§ 1447(c) basis." *Giles*, 172 F.3d at 336. The district court explained that it had supplemental jurisdiction over Thorn's claim, but it was exercising its discretion under 28 U.S.C. § 1441(c) to remand. As in *Giles*, "the court affirmatively gave a non-§ 1447(c) reason for remanding and gave no indication that it believed it lacked subject matter jurisdiction." *Id.* Accordingly, "we review the district court's exercise of its discretion to remand supplemental . . . state law claims." *Id.*

The district court held that even though Thorn stated only state law causes of action, it had supplemental jurisdiction over his claims, because they were joined to Calad's claims. Thus, the court's jurisdiction over Thorn's claims depended on its removal power over Calad's claims.[15] But, as we have explained, the district court never had removal jurisdiction over Calad's claims. Consequently, it never had subject matter over Thorn's claims, so remand was mandatory, not discretionary.[16]

C. The Roarks' motion to remand

The Roarks' original complaint, filed in state court, stated claims under the THCLA, the DTPA, the Texas Insurance Code, and common law breach of good faith, fair deal-

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15 *See* 28 U.S.C. § 1441(c) (hinging removal of supplemental claims on the existence of "a separate and independent claim or cause of action within the jurisdiction conferred by section 1331").

16 *Avitts v. Amoco Prod. Co.*, 53 F.3d 690, 693 (5th Cir. 1995) (explaining that if district court never had original jurisdiction over any federal claim, it could not have exercised supplemental jurisdiction over the joined state claims and was required to remand).

ing, and contract. Humana removed, citing ERISA preemption, and the Roarks moved to remand. Only after the district court affirmed the removal, concluding ERISA § 502(a) completely preempted the Roarks' DTPA and insurance claims, did the Roarks amend their complaint to state only THCLA claims. The Roarks made a second motion to remand, which the district court again denied; the Roarks appeal only the second denial.

If, at the time of removal, the complaint stated at least one cause of action completely preempted by § 502(a), the district court could have asserted jurisdiction over the entire case, including any claims only conflict-preempted by ERISA § 514 and any state law claims. *See* 28 U.S.C. § 1441(c);[17] *Giles*, 172 F.3d at 337-38.[18] Although the

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17 Section 1447(c) provides,

> Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

28 U.S.C. § 1447(c).

18 In *Giles* we explained,

> Hence, when a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction. When a complaint contains only state causes of action that the defendant argues are merely conflict-preempted, the court must remand for want of subject matter jurisdiction. When a complaint raises both completely-preempted claims and arguably conflict-preempted claims, the court may exercise removal jurisdiction over the completely-

[Footnote continued on next page]

Roarks do not appeal the initial holding that § 502(a) completely preempts some of their original claims, we must examine it on our own initiative, because this question determines whether the district court had subject matter jurisdiction. *McClelland*, 155 F.3d at 511, 518 n.39. We review this preemption question *de novo*, *id.* at 511, and conclude the district court did have jurisdiction.

Count six of the Roarks' original complaint alleges breach of contract: "By virtue of the policies provided to the Plaintiffs, Defendants assumed obligations, as outlined in the Member Materials and other documents provided to policy enrollees like the Roarks, to provide medically necessary treatment . . . . Defendants breached this promise to Mrs. Roark, causing her to suffer direct and serious damage." The Roarks assert that the plan's term "medically necessary treatment" includes VAC treatments.

The answer turns on interpreting the plan's language, not on applying an external, statutorily imposed standard of ordinary care. Because this is precisely the type of contract claim we recognize under § 502(a)(1)(B), *see supra* part II.A.2, this claim is completely preempted under ERISA.

This establishes that the district court had the power to entertain the Roarks' suit; it does not necessarily mean the court acted properly in doing so. The Roarks amended their complaint to state only THCLA claims, then filed a second remand motion, arguing that because all federal claims had been dismissed, 28 U.S.C. § 1367 required the court to remand the remaining supplemental state law claims. The dis-

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[Footnote continued from previous page]

> preempted claims and supplemental jurisdiction (formerly known as "pendant jurisdiction") over the remaining claims.

Giles, 172 F.3d at 337-38.

trict court ruled that the THCLA claims also were completely preempted under ERISA, so it had original jurisdiction over them and retained the case.

Because ERISA does not completely preempt the Roarks' THCLA claims, *see supra* part II, the district court had only supplemental, not original, jurisdiction over the Roarks' THCLA claims. "We review a district court's decision to retain jurisdiction over pendant [i.e., supplemental] state law claims for abuse of discretion." *McClelland*, 155 F.3d at 519; *see also* § 1367.

Section 1367(3) allows a district court to "decline to exercise supplemental jurisdiction over a claim . . . if . . . the district court has dismissed all claims over which it has original jurisdiction." 28 U.S.C. § 1367(3). The district court should evaluate whether remand furthers "the values of economy, convenience, fairness, and comity." *Carnegie-Mellon Univ. v. Cohill*, 484 U.S. 343, 351 (1988); *accord Brown v. Southwestern Bell Tel. Co.*, 901 F.2d 1250, 1254-55 (5th Cir. 1990).

III. Dismissal of the Roarks' claims

The district court dismissed the Roarks' THCLA claims under rule 12(b)(6), citing ERISA § 514 preemption. We review a rule 12(b)(6) dismissal *de novo*. *E.g.*, *Oliver v. Scott*, 276 F.3d 736, 740 (5th Cir. 2002).

ERISA § 514 preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a). We have spilled much ink over the past few decades trying to interpret this statute. By contrast, our answer today is short and direct: Our decision in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), is on point. Although the Supreme Court has since cast doubt on *Corcoran*'s validity, we do not write on a clean slate. Our rule of orderliness prevents

one panel from overturning the decision of a prior panel, so any relief for the Roarks must come from an en banc panel of this court or the Supreme Court. *Teague v. City of Flower Mound*, 179 F.3d 377, 383 (5th Cir. 1999).

Corcoran is factually indistinguishable from the Roarks' case. There, the HMO ignored its doctor's recommendation to hospitalize Mrs. Corcoran or monitor her pregnancy around the clock; instead it provided the less expensive treatment of ten hours a day of home nursing. *Corcoran*, 965 F.2d at 1324. While no nurse was on duty, Corcoran miscarried. *Id.* She sued her HMO, alleging its negligence caused her baby's wrongful death. *Id.*

We rejected both the HMO's "position that no part of its actions involve[d] medical decisions" and Corcoran's position "that no part of [her HMO's] actions involve[d] benefit determinations." *Id.* at 1332. In actuality, we explained, the HMO "makes benefit determinations as part and parcel of its mandate to decide what benefits are available under the [ERISA] plan." *Id.* "[F]rom this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination." *Id.*

Such a claim, we reluctantly concluded, was preempted under § 514. We recognized the possible harm our ruling created: ERISA provided no cause of action for medical malpractice; if ERISA also preempted all state medical malpractice claims, patients such as the Corcorans would be left with no remedy for potentially serious mistakes. *Id.* at 1338. But, we were bound by Supreme Court precedent, which at that time articulated an expansive view of ERISA preemption.

For example, we cited *Ingersoll-Rand* for the proposition that § 514's broad "relates to" language negated the normal rules of preemption. We would not assume that preemption was less likely in areas of "traditional state authority."[19] And, based on the broad language of *Pilot Life*, *Ingersoll-Rand*, and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), we concluded that even attenuated and indirect effects on an ERISA plan are enough to bring a statute within § 514 preemption. *Corcoran*, 965 F.2d at 1328-29, 1338 n.20.

Since then, the Supreme Court has curtailed the scope of § 514 preemption, most notably in a "trilogy" of cases between 1995 and 1997. The first case, *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), involved a New York statute requiring hospitals to collect surcharges from patients insured by a commercial carrier but exempting HMO's that provided open enrollment coverage. The Second Circuit had held that such surcharges "related to" ERISA plans: Many of these HMO's contracted with ERISA plans, and the surcharge, by affecting these HMO's' economic incentives, had an impact on plan structures.

The Court reversed in a unanimous opinion. The state statute's "indirect economic influence," the Court explained, "does not bind plan administrators to any particular choice." *Id.* at 659. It only alters "the relative costs of competing insurance to provide them," *id.* at 660, and this does not run afoul of ERISA preemption.

Two years later, a unanimous Court handed down *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.,*

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19 *Corcoran*, 965 F.2d at 1334, *see also Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1468 (5th Cir. 1986).

N.A., Inc., 519 U.S. 316 (1997). California had enacted a law that required payment of prevailing wages to employees in apprenticeship non-state approved programs but allowed lower wages for apprentices participating in state approved programs. The Court held that because the law was indifferent to ERISA coverage (state-approved programs did not have to be ERISA programs), the law did not make "reference to" such plans. *Id.* at 325.

The fact that "most state-approved apprenticeship programs . . . appear to be ERISA programs" was immaterial. *Id.* at 327 n.5. Nor did California's law have a "connection with" ERISA plans. It did not bind plans, legally or practically, to a given result; it only provided economic incentives to alter their structure. *Id.* at 329. Most notably, the Court explicitly returned to a traditional preemption analysis: ERISA's "relates to" language did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by the Federal Act." *Id.* at 331 (internal quotation marks omitted).[20]

The last of the trilogy, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), held that ERISA did not preempt New York's tax on gross receipts for patient services at health care facilities. The Court acknowledged that the tax had a direct effect on ERISA plans (in fact, it eschewed any distinction between direct and indirect effects), but still upheld the statute.

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20 Justice Scalia, in a concurrence in which Justice Ginsburg joined, urged the Court to "acknowledge[ ] that our first take on this statute was wrong; that the 'relate to' clause . . . is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies." *Id.* at 336 (Scalia, J., concurring).

The trilogy undermines *Corcoran* in two important ways. First, the Court established that traditional preemption rules apply under ERISA. Thus, courts should presume ERISA does not preempt areas such as "general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. Second, the Court held that a state law's economic impact (direct or indirect) on plan structures is not enough to trigger § 514 preemption.

The Court's *dictum* in *Pegram* gives further reason to doubt that ERISA preempts medical malpractice claims such as the Roarks'. In holding that the plaintiff did not state a claim under 502(a)(2), the Court, 530 U.S. at 236-37, expressed disbelief that ERISA preempts such claims:

> To be sure [*Travelers*] throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA.

Pegram, 530 U.S. at 236-37.

Furthermore, after *Pegram*, *Corcoran*'s rule creates perverse incentives for HMO's. If a doctor fails to recommend treatment, the patient may sue the doctor and HMO under state law. If the doctor recommends treatment, and the HMO denies coverage, the patient has no remedy. *Corcoran*, 965 F.2d at 1338. In this circuit, HMO's can escape all liability if they instruct their doctors to recommend every possible treatment and leave the real decision to HMO administrators. It is difficult to believe that one of Congress's goals in passing ERISA was to shift medical judgments from doctors to plan administrators.

If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by *Corcoran*. Accordingly, we affirm with respect to the Roarks.

In summary, the judgment in No. 01-10831, regarding the Roarks, is AFFIRMED. The judgment in No. 01-10891 is REVERSED in regard to Calad and AFFIRMED in regard to Thorn. The judgment in No. 01-10905 is REVERSED in regard to Davila. All these matters are REMANDED to the respective district courts for further proceedings, if any, that may be called for by this opinion.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

[Filed June 29, 2001]

JUAN DAVILA	§	
	§	
VS.	§	ACTION NO.
	§	4:00-CIV-1855-Y
AETNA U.S. HEALTHCARE	§	
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	

ORDER DENYING MOTION TO REMAND AND GRANTING MOTION TO DISMISS

Pending before the Court is Plaintiff's Motion to Remand, which was filed in this cause on January 25, 2001. Also pending before the Court is Defendants' Rule 12(b)(6) Motion to Dismiss for Failure to State a Claim Upon Which Relief Can Be Granted, which was filed on February 28. After reviewing all of the briefs regarding these motions and the applicable law, the Court concludes that Plaintiff's motion should be denied, and Defendants' motion should be granted, for the reasons urged by Defendants.

Plaintiff originally filed suit against Defendants in the 67th Judicial District Court of Tarrant County, Texas, asserting a claim under the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE § 88.001, *et seq.* (Vernon Supp. 2001). Plaintiff contends that Defendants, who administer

health-care-benefits claims under a plan established by Plaintiff's employer, negligently and wrongfully practiced inferior medicine through the use of their prescription-drug formulary. Specifically, Plaintiff complains that although his doctor wanted to prescribe the drug "Vioxx" for Plaintiff's arthritis pain, Defendants refused to cover the medication. (Pl.'s Pet. at 1-2.) Defendants' refusal was based upon its prescription-drug formulary, which was developed through their utilization-review program. (Pl.'s Pet., Ex. 2 to Ex. A.) Under this formulary, coverage for Vioxx is not provided unless the insured has a "contraindication, intolerance, allergy to or a documented adequate trial of at least two (2) formulary (non-steroidal anti-inflammatory drugs]." (Pl.'s Pet., Ex. 2 to Ex. A.) Consequently, Plaintiff's doctor instead prescribed naprosyn for Plaintiff's arthritis pain, which allegedly caused Plaintiff to suffer bleeding ulcers that nearly resulted in a heart attack and required his hospitalization in critical care for several days. (Pl.'s Pet. at 5.)

Defendants removed Plaintiff's claim to this Court, contending that federal-question jurisdiction exists because Plaintiff's state-law claim is completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"). As a result, Defendants also request that Plaintiff's state-law claim be dismissed and that he be required to assert his claim under ERISA instead. Plaintiff seeks remand, urging that ERISA does not completely preempt his claim and that, as a result, federal-question jurisdiction is lacking and removal therefore was improper.

Defendants, as the removing parties, have the burden of establishing that this Court has jurisdiction over Plaintiffs' claims. *See Carpenter v. Wichita Falls Indep. Sch. Dist.*, 44 F.3d 362, 365 (5th Cir. 1995). The question of whether federal jurisdiction exists is generally determined according to the "well-pleaded-complaint rule." *Franchise Tax Bd. v.*

Construction Laborers Vacation Trust, 463 U.S. 1, 9-10 (1983). Under this rule, "federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint; a federal defense does not confer subject-matter jurisdiction." *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 160 (3d Cir. 1999). Unquestionably, Plaintiff's petition does not assert a federal claim on its face.

Defendants contend that federal-question jurisdiction nevertheless exists, and that removal was therefore proper, based on the complete-preemption doctrine. The complete-preemption doctrine "functions as an exception to the well-pleaded complaint rule; 'Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character.'" *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 336-37 (5th Cir. 1999) (quoting *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987)). If the state law upon which a plaintiff's claim is based is completely preempted, a federal question is presented regardless of how the plaintiff couches the claim, and removal to federal court is proper. *Id.* at 337. Nevertheless, complete preemption applies only in extraordinary circumstances; it requires a clear expression of congressional intent to make a cause of action removable. *Aaron v. National Union Fire Ins. Co.*, 876 F.2d 1157, 1163 (5th Cir. 1989), *cert. denied*, 493 U.S. 1074 (1990).

Complete preemption occurs under ERISA when a state-law claim fits within the scope of the civil-enforcement provision found in section 502 of ERISA. *See* 29 U.S.C. § 1132; *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995).

ERISA's civil-enforcement provision establishes a federal cause of action whenever an ERISA-plan participant or

beneficiary seeks to recover benefits due or to enforce or clarify rights under the plan. 29 U.S.C. § 1132(a)(1)(B).[1]

ERISA also contains a second type of preemption known as "ordinary" or "conflict" preemption. Section 514 of ERISA provides that ERISA's provisions "supersede any and all State common laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although section 514's "conflict" preemption has been broadly construed, it nevertheless is defensive in nature and therefore provides no basis for removal jurisdiction under the well-pleaded-complaint rule. *Giles*, 172 F.3d at 337. Thus, "when the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding [§ 514(a)] preemption." *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995). Rather, it must remand to state court, and that court will resolve the § 514(a) preemption issue.

Plaintiff contends that his claim challenges only the quality of care he received as a result of Defendants' participation, through its formulary, in his treatment. When a plaintiff attacks only the quality of care he has received under an ERISA plan, that is, when he attacks decisions made about his medical treatment, his claim does not arise under § 502 of ERISA and thus is not completely preempted. *See Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d. 266, 272-73 (3d Cir. 2001). "On the other hand, a claim alleging that an

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[1] Additionally, a civil action may be brought under ERISA to obtain relief for a breach of the fiduciary duties or violations of the statutory reporting requirements established by ERISA. 29 U.S.C. § 1132(a)(1)(A) & (a)(2).

HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits" and, as a result, would be completely preempted under ERISA. *Id.* at 273. Thus, the Court must determine whether Plaintiff's "claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action." *Id.*

Despite Plaintiff's attempt to pepper his petition with quality-of-care and medical-treatment allegations, the Court concludes that Plaintiff's claim, fairly construed, actually challenges the administration of health benefits under an ERISA plan. Plaintiff challenges Defendants' adherence to its prescription-drug formulary despite his doctor's recommendation. Plaintiff claims that Defendants refused to provide coverage for the drug his doctor recommended and instead required that he first try a less-expensive drug that caused side effects. Plaintiff contends that Defendants' formulary policies amounted to the improper practice of medicine. What Plaintiff really challenges, however, is Defendants' determination regarding which particular drugs are covered under the plan and the circumstances of that coverage. The Court concludes that, distilled to its essence, Plaintiff's claim against Defendants concerns their administration of benefits under the plan, rather than the quality of care he received. As a result, his state-law claim is completely preempted by ERISA, federal-question jurisdiction exists, and removal was proper.

Normally, the Court would dismiss Plaintiff's state-law claim but grant him leave to file an amended complaint asserting a claim under ERISA. Plaintiff's response to Defendants' Motion to Dismiss indicates, however, that Plaintiff does not desire to pursue an ERISA claim. *See* Pl.'s Resp. to

Defs.' Mot. to Dismiss and Reply to Defs.' Resp. to Pl.'s Mot. to Remand at 2-3. As a result, Plaintiff's state-law claim will be dismissed without leave to amend.

It is, therefore, ORDERED that Plaintiff's Motion to Remand [document number 5-1] is DENIED.

It is further ORDERED that Defendants' Motion to Dismiss [document number 13-1] is GRANTED. Plaintiff's state-law claim is DISMISSED WITH PREJUDICE to the refiling of same.

SIGNED June 29, 2001.

/s/
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10831

[Filed April 15. 2003]

ROBERT ROARK; ROBERT ROARK, on behalf of the Estate of Gwen Roark.

Plaintiffs – Appellants

v.

HUMANA INC; HUMANA HEALTH PLAN OF TEXAS INC, doing business as Humana Health Plan of Texas (Dallas), doing business as Humana Health Plan of Texas (San Antonio), doing business as Humana Health Plan of Texas (Corpus Christi); HUMANA HMO TEXAS INC

Defendants - Appellants

Case No. 01-10891

RUBY R CALAD

Plaintiff - Appellant-Cross-Appellee

and

WALTER PATRICK THORN

Plaintiff - Cross-Appellee

v.

CIGNA HEALTHCARE OF TEXAS INCORPORATED, doing business as Healthsource, doing business as Cigna Corporation

Defendant - Appellee

AETNA US HEALTHCARE, AETNA U S HEALTHCARE OF NORTH TEXAS, INC

Defendants - Appellees-Cross-Appellants

Case No. 01-10905

JUAN DAVILA

Plaintiff - Appellant

v.

AETNA US HEALTHCARE, INC; AETNA US HEALTHCARE OF NORTH TEXAS, INC

Plaintiffs - Appellants

Defendants - Appellees

Appeals from the United States District Court for the Northern District of Texas, - Dallas

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ON PETITION FOR REHEARING AND REHEARING EN BANC

(Opinion 9/17/02, 5 Cir., _____, _____ F.3d _____)

Before SMITH and BENAVIDES, Circuit Judges.*

PER CURIAM:

(X) The Petition for Rehearing filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc filed by Aetna Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is also DENIED.

( ) The Petition for Rehearing filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service not having voted in favor, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor, Rehearing En Banc filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED.

ENTERED FOR THE COURT:

/s/ JERRY E. SMITH
United States Circuit Judge

REHG-4A

*Judge Parker, a member of the panel, is retired and did not participate in consideration of rehearing. This matter is decided by a quorum pursuant to 28 U.S.C. § 46(d).

Judge Jones is recused and did not participate in the consideration of rehearing.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

[Filed June 29, 2001]

JUAN DAVILA	§	
	§	
VS.	§	ACTION NO.
	§	4:00-CIV-1855-Y
AETNA U.S. HEALTHCARE	§	
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	

FINAL JUDGMENT

In accordance with the order issued this same day and Federal Rule of Civil Procedure 58,

It is hereby ORDERED, ADJUDGED, and DECREED that all claims are hereby DISMISSED WITH PREJUDICE to their refiling. All costs of Court under 28 U.S.C. § 1920 shall be borne by Plaintiff.

SIGNED June 29, 2001.

/s/
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

APPENDIX E

The Supremacy Clause of the Constitution of the United States provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution of Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

APPENDIX F

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER 1—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * *

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6) of subsection (c) or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021, of this title or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of title 42.

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other

person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 1145 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 by a party in interest

with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of title 26.

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this chapter by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of title 26.

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount

equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

* * * * *

§ 1144. Other laws.

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which

any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited.

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

APPENDIX G

TEXAS CIVIL PRACTICE AND REMEDIES CODE
TITLE 4. LIABILITY IN TORT
CHAPTER 88. HEALTH CARE LIABILITY

§ 88.001. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness

insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed

care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

§ 88.002. Application

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being li-

censed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

§ 88.003. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with or otherwise complies with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsections (c) and (d).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under Subsection (c) as requested by a health insurance carrier, health maintenance organization, or managed care entity must be performed in accordance with Article 21.58C, Insurance Code. The health insurance carrier, health maintenance organization, or managed care entity requesting the review must agree to comply with Subdivisions (2), (3), and (4), Section 6A, Article 21.58A, Insurance Code.

(e) Subject to Subsection (f), if the enrollee has not complied with Subsection (a), an action under this section shall

not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(f) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (e).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(h) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

APPENDIX H

CAUSE NO. 067-185326-00

JUAN DAVILA	§	IN THE
	§	DISTRICT COURT
Plaintiff,	§	
	§	
	§	TARRANT
v.	§	COUNTY, TEXAS
	§	
AETNA U.S. HEALTHCARE INC., AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.	§	
	§	
	§	
	§	
	§	___ JUDICIAL
Defendants.	§	DISTRICT

PLAINTIFF'S ORIGINAL PETITION

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES PLAINTIFF, Juan Davila, to file this his Original Petition against Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. (collectively "Aetna" or "Defendants"), and would respectfully show the Court as follows.

I.

DISCOVERY CONTROL PLAN

1. Discovery is intended to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

II.

OVERVIEW

2. This claim is brought pursuant to the Texas Health Care Liability Act, Tex. Civ. Prac. & Rem. Code §§ 88.00, *et seq.*, complaining of AEtna's negligent and wrongful use of its prescription drug formulary policies to practice improper medicine; that is, to divert Juan Davila from access to prescription medications that his treating physician believes are most safe and effective. The Vioxx Juan Davila's treating physician wanted to prescribe is on AEtna's formulary. However, through its formulary policies, which amount to the improper practice of medicine, AEtna directly and adversely affected and influenced the *quality* of the medical care and treatment provided to Juan Davila, forcing his treating physician to first prescribe a less effective drug with worse side effects than Vioxx. Juan Davila suffered one of the worst of these side effects, thanks to Aetna, a bleeding ulcer that almost killed him.

A. AEtna's Denial of Juan Davila's Treating Physician's Recommended Prescription Treatment

3. In Juan Davila's case, despite the recommendations and protests of his treating physician, AEtna refused to provide Vioxx for relief of the pain caused by Juan Davila's arthritis his treating physician prescribed, *despite Vioxx being on the AEtna formulary.* Instead, pursuant to AEtna's own formulary policies, Juan's primary care physician was forced to prescribe naprosyn, a cheaper generic pain reliever. Naprosyn has also been shown in studies to have incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach, significantly higher than Vioxx.

4. As a result of AEtna's naprosyn substitution, Juan Davila began to suffer bleeding ulcers, ultimately resulting in his being rushed to the emergency room on July 20, 2000 after a near-heart attack. Both a specialist and a nurse at the

hospital told the Juan Davila that Naprosyn sometimes caused these problems.

5. AEtna's adherence to its own prescription formulary policies, despite the recommendations of his own creating physician, directly affected and influenced the quality of care provided to Juan Davila, culminating in his hospitalization and near-death, the effects of which he continues to suffer.

III.

PARTIES

6. Plaintiff, Juan Davila, is an individual who resides in Denton, Texas.

7. Defendant AETNA U.S. HEALTHCARE, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Suite 300, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

8. Defendant AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Dallas, Texas 75207 with citation and a copy of this Petit ion attached thereto.

IV.

JURISDICTION & VENUE

9. Jurisdiction is proper in this Court because the amount in controversy in this case exceeds the jurisdictional limits of State District Courts in Texas.

10. Venue is proper in Tarrant County, Texas because AEtna maintains a principal office in Tarrant County. *See* Tex. Civ. Prac. & Rem. Code § 15.002(a)(3). Specifically, while

AEtna has offices in other parts of the State of Texas, AEtna maintains a principal place of business in Tarrant County, Texas, where decision makers of substantially equal responsibility and authority conduct business.

V.

FACTS

A. AEtna's Prescription Drug Formulary Policies Directly Influenced and Controlled the Treatment Afforded Juan Davila and the Quality of that Care

11. Juan Davila is 48 years old, and a resident of Ponder, Texas. Mr. Davila obtained his AEtna PPO health coverage through his employer, Monitronics, where he screens house-signaled house alarms. Monitronics played no role in determining which medications are included in the AEtna drug formulary; instead, drug formulary medical policy is determined solely by AEtna, based largely on cost factors rather than effectiveness and potential side effects and harm to patients.

12. Juan is a post-polio patient, diabetic and suffers from arthritis. In April of 2000, Dr. Joseph Lopez, Juan's primary care physician, prescribed Vioxx to ease the pain and discomfort Juan was having associated with his arthritis. Compared to the other drugs on the AEtna formulary, Vioxx has been shown in studies to have a lower incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach. When Juan tried to fill the prescription, however, he was informed that his insurer, AEtna PPO, would not fill it, *even though Vioxx is on the AEtna formulary.*

13. In order to save its shareholders money, AEtna determined to dictate the practice of medicine delivered to its members. AEtna informed Dr. Lopez that Juan must be placed in a "step program" to get to Vioxx. Before Vioxx

would be permitted, Juan would have to be placed on two (2) different medications, and suffer a detrimental reaction to these drugs or show no signs of improvement. *Only then* would Juan be medically evaluated by AEtna for Vioxx. Despite Dr. Lopez's protests, AEtna's decision to refuse his prescription for Vioxx was final, and naprosyn was prescribed.

14. After being on naprosyn for several weeks, Juan began to experience weakness and related symptoms in late June. He was rushed to the emergency room on July 20, 2000, where it was discovered that he suffered from bleeding ulcers, resulting in a near-heart attack. In the emergency room, Juan was administered seven units of blood; indeed, doctors at the emergency room told Juan hew as within hours of dying from internal bleeding.

15. Juan was kept in critical care for five (5) days during which time a specialist and a nurse said the Naprosyn sometimes causes these types of problems. Juan was subsequently readmitted to the hospital for further complications, but is currently recovering at home. As a result of AEtna's improper dictation of the practice of medicine in delaying the prescription of Vioxx, and forcing on Juan Davila the cheaper but inappropriate naprosyn, Juan will not be able to take any other pain medication for his arthritis-related pain which has to be absorbed through the stomach, including aspirin.

VI.

CAUSE OF ACTION

A. Texas Health Care Liability Act

16. Plaintiff hereby incorporates Paragraphs 1 through 15 above, inclusive.

17. This claim is brought pursuant to §§ 88.001, *et seq.*, of the Civil Practice & Remedies Code. As described above, AEtna failed to use ordinary care in influencing, controlling,

participating in and making health-care treatment decisions regarding Juan Davila through its adherence to its prescription drug formulary policies. The AEtna Defendants each served as managed care entities exercising control and/or influence over the medical care received by Juan Davila. By definition, a "managed care entity" includes any entity which delivers, administers, or assumes risk for, health care services. *See* Tex. Civ. Prac. & Rem. Code, § 88.001(8).

18. Medical services were actually provided to plaintiff by the Aetna Defendants. Through its formulary policies, AEtna controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided to Plaintiff, violating the duty of ordinary care set forth in §§ 88.001 and 88.002. Such violation of ordinary care was the proximate cause of Plaintiffs damages, as described herein.

19. The AEtna Defendants, either jointly or singularly as the evidence may show, failed during the time in which they were influencing, controlling, participating in or providing health care treatment decisions to Juan Davila to provide him with appropriate quality care within the managed care standard of care for the treatment of his arthritis. Additionally, the AEtna Defendants put systems in place such as to make such sub-standard care more likely than not.

20. Each and every one of the foregoing acts of omission and commission, taken separately and collectively, constituted the direct and proximate cause of injuries suffered by Plaintiff. Accordingly, Plaintiff brings suit for his damages pursuant to § 88.001 *et seq.* of the Texas Civil Practices and Remedies Code. AEtna's actions with regard to the management of Juan Davila's care through its prescription drug formulary policies constitutes negligence that has been the proximate cause of significant damages to Plaintiff herein.

21. Plaintiff has fulfilled all requirements of § 88.001, *et seq.*, which are prerequisites to this suit. The expert re-

port of Joseph Lopez, M.D., is attached hereto and incorporated herein by reference, as required by Tex. Civ. Prac. & Rem. Code § 88.002(k). The independent review set forth in § 88.003 was of nc benefit prior to filing this suit and is of no benefit now—the harm has already occurred.

VII.

DAMAGES

22. Plaintiff hereby incorporates paragraphs 1 through 21 above, inclusive.

23. The foregoing aces and omissions, taken separately and collectively, were the direct and proximate cause of the harm caused to Plaintiff. Accordingly, Plaintiff sues for:

> Lost earnings, both past and future Pecuniary loss, both past and future Physical pain and mental anguish, both past and future

24. Plaintiff does not seek recovery for denial of any benefits, nor is he seeking payment for Vioxx. Notably, Mr. Davila's injuries cannot be remedied by any retroactive authorization or payment of any benefit. Plaintiff seeks relief based on Defendants' failure to use ordinary care in "influencing," "controlling," "participating in" and making health care treatment decisions through its prescription drug formulary medical policies, where care was actually provided.

VIII.

GROSS NEGLIGENCE/PUNITIVE DAMAGES

25. Plaintiff hereby incorporates Paragraphs 1 through 24 above, inclusive.

26. Plaintiff was the victim of a knowing, calculated scheme whereby the Aetna Defendants increased their profits by controlling and influencing the medically necessary care for patients such as Juan Davila through their prescription

drug formulary policies. The evidence will show that AEtna had both actual and subjective knowledge that their scheme involved an degree of risk which would lend to the serious injury or death of AEtna members such as Plaintiff. Nonetheless, AEtna put in place and enforced their formulary policies and system of health care delivery, with conscious indifference to the rights, safety and welfare of others and the injury such a system which would cause. Therefore, Plaintiff seeks punitive damages, pursuant to § 41.001, *et. seq.*, of the Texas Civil Practices & Remedies Code, against AEtna.

IX.

PLAINTIFF'S CLAIMS FOR DAMAGES NOT BARRED BY ART. 4590i, §§ 11.02-11.04, or CPRC § 41.008

27. Plaintiffs health care liability claims for damages against AEtna are not barred or limited by the Texas Medical Liability and Insurance Improvement Act, Tex. Rev. Civ. Stat. Ann. Art. 4590i, §§ 11.02, 11.03, and 11.04 (Vernon Supp. 1995) ("the Act"), which attempt to limit the maximum liability of physicians and certain health care providers, for medical or health care negligence in malpractice or health care liability claims only for the reasons that:

(a) Sections 11.02(a), 11.03, and 11.04 are arbitrary, unreasonable, and in violation of plaintiffs' rights to due process of law and/or equal protection of the laws under the Fifth and Fourteenth Amendments to the United States Constitution, and Article 1, sections 3 and 19 of the Texas Constitution, because (1) the damage limitation invidiously discriminates between seriously injured or death victims of medical or health care negligence or malpractice. (2) the damage limitation grants health care providers special immunity from damages over other tort-feasors, (3) the damage limitation fails to provide a reason-

able substitute for malpractice victims or their heirs who suffer damages in excess of that amount, (4) the damage limitation discriminates between medical malpractice victims and victims of other torts in general, (5) article 4590i and/or the damage limitation did not have a rational basis or was not justified in view of the absence of a so-called "medical malpractice crisis" or "medical malpractice insurance crisis," and (b) alternatively, the alleged crisis no longer exists;

(b) Sections 11.02, 11.03, and 11.04 are in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988);

(c) Sections 11.02, 11.03 and 11.04 are in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages;

(d) Sections 11.02, 11.03, and 11.04 unduly and unnecessarily restrict the plaintiffs' right to deal with the so-called "crisis" in violation of Tex. Rev. Civ. Stat. Ann. Art. 4590i, section 1.02(b) & (c); and

(e) Sections 11.02, 11,03, and 11.04 were declared unconstitutional by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988). They are thus dead statutes because they can only be in force and effect if they are passed again, in a constitutional form, by the Texas Legislature. These statutes cannot be "resurrected" by the courts. Thus, sections 11.02, 11.03, and 11.04 are not in force and effect, and do not operate to limit the plaintiffs' damages.

(f) In the alternative, the Defendants are not "providers" under the Act.

28. Further, Plaintiff s claims for exemplary damages against Defendants are not barred or limited by Texas Civil Practices & Remedies Code § 41.008, which attempts to limit The liability of Defendants for exemplary damages, for the reasons that:

(a) Section 41.008 is in violation of the open courts clause, article 1 section 3, of the Texas Constitution for the reasons stated b y the Texas Supreme Court *in Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); and

(b) Section 41.008 is in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages.

X.

PREJUDGMENT INTEREST

29. Plaintiff also seeks prejudgment interest as a matter of law on his damages described herein calculated in accordance with Tex. Rev. Civ. Stat., art. 5069-1.05, or upon such other terms, conditions, and rate, as allowed by law.

30. Plaintiff further requests the Court to take judicial notice of the rate of interest published by the Texas Consumer Credit Commission in the Texas Register on the date of judgment in this cause for purposes of calculating the rate of prejudgment interest to be awarded to plaintiffs in this cause, or such other periods of time, and such other rate or rates of interest allowed by law for determination of prejudgment interest.

XI.

DEMAND FOR JURY TRIAL

31. Plaintiff hereby demands a jury trial of the above entitled and numbered cause. The Plaintiff is entitled to a trial by jury in the above cause pursuant to the Texas Constitution, Art. I, Section 15, and Tex. R. Civ. P. 216.

32. Plaintiff sues Defendants jointly and singularly.

XII.

PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiff prays that he has judgment against all Defendants named herein, as follows:

a. That Plaintiff recover judgment from Defendants for Plaintiff's actual damages, in a total sum in excess of the jurisdictional limits of this court;

b. The Plaintiff recover judgment from the AEtna Defendants for exemplary damages, in a total sum in excess of the jurisdictional limits of this court;

c. That Plaintiff recover prejudgment interest on the amount accrued on the damage amount(s) at the highest legal rate allowed by law;

d. That Plaintiff recover post-judgment interest on the due amount at the highest legal rate from the date of judgement until it is paid;

e. That plaintiff recover all costs of court;

f. For such other and further relief, at law or in equity, to which he may show himself justly entitled.

Respectfully submitted,

/s/

George Parker Young
State Bar No. 22184750
Adam J. Williams
State Bar No. 24013753

FRIEDMAN, YOUNG, SUDER
& COOKE
500 Throckmorton, Suite 2000
Fort Worth, Texas 76102
Telephone: (817) 334-0400
Facsimile: (817) 334-0401

ATTORNEYS FOR PLAINTIFF

[Exhibit A to Original Petition]

CAUSE NO. _____

JUAN DAVILA	§	IN THE
	§	DISTRICT COURT
Plaintiff,	§	
	§	
v.	§	TARRANT
	§	COUNTY, TEXAS
AETNA U.S. HEALTHCARE INC., AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.	§	
	§	____ JUDICIAL
Defendants.	§	DISTRICT

AFFIDAVIT OF JOSEPH LOPEZ, M.D.

STATE OF TEXAS §
§
DENTON COUNTY §

BEFORE ME, the undersigned authority, on this day personally appeared Joseph Lopez, M.D., who, under oath, stated as follows:

1. "My name is Joseph Lopez. I am over twenty-one (21) years of age, have never been convicted of a felony or other crime involving moral turpitude, and suffer from no mental or physical disability that would render me incompetent to make this Affidavit. I have personal knowledge of each statement set forth herein, and each such statement is true and correct.

2. "I am Juan Davila's primary care physician under Mr. Davila's Aetna PPO healthcare plan. In April of 2000, I prescribed Vioxx to ease the pain and discomfort Mr. Davila was experiencing associated with his arthritis. Compared to other drugs on the AEtna formulary, Vioxx has been shown

in studies to have a lower incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach. Attached hereto as Exhibit '1' are copies of several such studies, and are hereby incorporated by reference. Reducing the likelihood of gastrointestinal toxicity was one of my chief concerns I had with respect to prescribing Vioxx for Mr. Davila.

3. "I was told by Mr. Davila that when he tried to have the prescription filled, AEtna refused to fill the prescription. After I contacted AEtna regarding its refusal, AEtna sent me a letter, a true and correct copy of which is attached hereto as Exhibit '2.'

4. "According to this letter, I would be required to prescribe at least two (2) formulary non-steroidal anti-inflammatory drugs ("NSAIDs"), to which Mr. Davila had a 'contraindication, intolerance, allergy to or a documented adequate trial' before a prescription for Vioxx would be approved. Therefore, the drug I had chosen based on my own experience and medical judgment as best-suited to treat Mr. Davila was rejected in favor of a cheaper, generic drug (naprosyn) which has been shown to have a higher incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforations of the stomach than Vioxx.

5. "Through AEtna's formulary policies, AEtna influenced and controlled my health care treatment decisions regarding Juan Davila, and directly affected the quality of care and treatment provided to Juan Davila.

6. "After Juan was on naprosyn for several weeks, he began to experience weakness and related symptoms in late June of 2000. At the emergency room, it was discovered that he suffered from bleeding ulcers, which resulted in a near-heart attack, and was within hours of dying from internal bleeding. As a result of these complications, Juan will not be able to take any other pain medication for his arthritis-related

pain which has to be absorbed through the stomach, including aspirin.

7. "I am familiar with the methods of operation and procedures of managed care entities with respect to their determinations of the medical necessity of treatments recommended for their members. I am also familiar with AEtna's formulary policies as set forth above. In Mr. Davila's case, AEtna's formulary policies which required that Mr. Davila be subjected to two (2) different, potentially more dangerous, NSAIDS before being evaluated for Vioxx, despite Vioxx being on the AEtna formulary, fell below the standard of ordinary care for similarly situated managed care entities, and, in ray opinion, resulted in the gastrointestinal injury to Mr. Davila.

"FURTHER AFFIANT SAYETH NOT."

/s/
JOSEPH LOPEZ, M.D.

SWORN TO AND SUBSCRIBED before me by Joseph Lopez, M.D. on this the 19th day of October, 2000, to certify which witness my hand and official seal of office.

[SEAL] /s/
Notary Public in and for
The State of Texas

[Exhibit 1 to Affidavit of Joseph Lopez, M.D. Omitted]

[Exhibit 2 to Affidavit of Joseph Lopez, M.D.]

[Seal]

May 10, 2000

DR LOPEZ
FAX# 940-382-4447

Re: JUAN DAVILA
Member ID: BBCXM3HA

Dear Doctor

As a part of our commitment to provide access to quality care for our members, Aetna U.S. Healthcare conducts a utilization review program with physicians, hospitals, and others who provide care, services and equipment to our members. A request for authorization of coverage of the drug Vioxx has been reviewed. The member's benefit design requires precertification for this drug in the Aetna U.S. Healthcare Medication Formulary Guide ("Formulary"). Precertification for Vioxx will be approved if the member has a diagnosis of osteoarthritis or acute pain and has a contraindication, intolerance, allergy to or a documented adequate trial of at least two (2) formulary NSAIDs. Covered alternative medications in this therapeutic class include ibuprofen, naproxen, Arthrotec, diclofenac sodium, erodoiac, iodomethacin/SR, telmetin, piroxicarn, sulindac, or fenoprofen. Based on the review of information submitted to us, your request to authorize payment for the Formulary excluded medication has been denied.

Aetna U.S. Healthcare makes coverage decisions based on nationally recognized standards of care established by governmental regulatory agencies, scientific evidence in the peer reviewed medical literature, input from physicians recog-

nized to be expert in the area and guidelines established by professional societies.

If the member, or the provider on behalf of the member, wishes to take exception to this decision he/she may file a formal grievance with the HMO. A formal grievance may be filed by calling our Member Services Department using the phone number displayed on the member enrollment card, to request a description of the Aetna U.S. Healthcare Grievance Resolution Procedures, or by submitting a complete, written explanation of his/her grievance, together with a copy of this letter and any supporting documentation, to the U.S. Healthcare Grievance Department, Aetna US Healthcare P.O. Box 150927 Arlington, TX 76015-0927 or refer to the member handbook. An expedited appeal may be requested for life threatening conditions or for a patient already in the hospital.

You have the right to review by an Independent Review Organization (IRO) of adverse coverage determinations based on medical necessity. If the adverse determination involves a life-threatening condition, you have the right to request immediate review by an IRO. Contact Member Services or you may contact the Texas Department of Insurance if you wish to request an IRO.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

By Telephone	In writing
1-800-252-3439	P.O. Box 149184
or Fax to 512-274-1771	Austin, TX 78715

Note: The health plan's time limit for review of your appeal will not begin until your request for appeal is received.

Sincerely,

Nancy Nelson, Pharm D.
Aetna U.S. Healthcare Inc.

APPENDIX I

NO. 067-185326-00

JUAN DAVILA	§	IN THE DISTRICT
	§	COURT
Plaintiff,	§	
	§	
VS.	§	
	§	TARRANT
AETNA U.S. HEALTHCARE	§	COUNTY, TEXAS
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	67TH JUDICIAL
NORTH TEXAS, INC.	§	DISTRICT
	§	
Defendants.	§	

NOTICE OF REMOVAL OF STATE COURT ACTION

TO: Plaintiff Juan Davila, by and through his attorney of record, George Parker Young, Friedman, Young, Suder & Coolie, P. O. Box 2308, Fort Worth, Texas 76113

You are hereby notified that on the 12th day of December, 2000, a Notice of Removal of Civil Action, a true and correct copy of which is attached hereto, was filed in the United States District Court for the Northern District of Texas, Fort Worth Division. The Notice of Removal was filed in reference to Cause No. 067-185326-00: *Juan Davila v. Aetna U.S. Healthcare, Inc, and Aetna U.S. Healthcare of North Texas. Inc.*: then pending in the 67th Judicial District Court of Tarrant County, Texas.

Respectfully submitted,

Andrews & Kurth, L.L.P.

By:_____/s/_____
John B. Shely
State Bar No. 18215300
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200
Facsimile: (713) 220-4285

David Broiles
State Bar No. 03054500
500 Main Street, Suite 1200
Fort Worth, Texas 76102
Telephone: (817) 335-7733
Facsimile: (817) 335-7733

ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been delivered to the following counsel by certified mail, return receipt requested, no. Z 330 913 329 on the 12th day of December, 2000:

Mr. George Parker Young
Friedman, Young, Suder & Cooke
P.O. Box 2508
Forth Worth, Texas 76113

_____/s/_____
John B. Shely

APPENDIX J

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
v.	§	CIVIL ACTION
	§	NO. _____
AETNA U.S. HEALTHCARE	§	
INC., AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	
	§	
Defendants.	§	

NOTICE OF REMOVAL OF CIVIL ACTION

Defendants Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc., referred to collectively as "Aetna," file this Notice of Removal of the action brought against them by Plaintiff Juan Davila. The grounds in support of this Notice of Removal are as follows:

I.

The Aetna Defendants have been named in a civil action filed on or about November 9, 2000 in the 67th Judicial District Court of Tarrant County, Texas ("State Court Action"). (A true and correct copy of the Plaintiff s Original Petition is attached as Exhibit 1 and incorporated herein for all purposes.)

II.

Aetna U.S. Healthcare, Inc, and Aetna U.S. Healthcare of North Texas, Inc. were both served with or otherwise received a copy of the initial pleading on or about November 14, 2000. (True and correct copies of the citations received by Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. are attached hereto as Exhibit 2 and 3, respectively.) On December 1, 2000, Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. filed their Original Answer in the State Court Action to avoid being in default in the State Court Action. (A true and correct copy of their Original Answer is attached hereto as Exhibit 4).

III.

This Notice of Removal of Civil Action is timely pursuant to 28 U.S.C. § 1446(b) because the State Court Action is being removed within the statutorily allowed thirty day period after the date the first Defendant was served with or otherwise received a copy of the initial pleading and citation.

IV.

Plaintiffs' State Court Action may be removed to this Court because it arises under the laws of the United States. Plaintiff Juan Davila was a participant in an employee benefit plan established and maintained by his employer, Monitronics International Inc., pursuant to the Employee Retirement Income Security Act of 1974, as amended, (ERISA), 29 U.S.C. § 1001 *et seq.* (the "Monitronics Plan"). Aetna U.S. Healthcare of North Texas, Inc. is a health maintenance organization that provides various administrative services to the Monitronics Plan, including making claims determinations as to claims for benefits for medical expenses, including prescription drugs. These claims determination functions include making coverage determinations with respect to whether members' claims for benefits are medically neces-

sary as defined by the terms of the Monitronics Plan. All of Plaintiff s claims arise from Aetna U.S. Healthcare of North Texas, Inc.'s allegedly wrongful denial of benefits for a medication prescribed by Plaintiffs physician, which Plaintiff maintains was covered under the terms of the Monitronics Plan. For example, Plaintiff alleges:

- "Mr. Davila obtained his AEtna PPO health coverage through his employer, Monitronics . . ."[1]
- "Juan's primary care physician[] prescribed Vioxx to ease the pain and discomfort Juan was having. . ."[2]
- "When Juan tried to fill the prescription, however, he was informed that his insurer, AEtna PPO, would not fill it, *even though Vioxx is on the AEtna* formulary."[3]
- "AEetna informed Dr. Lopez that . . . [b]efore Vioxx would be permitted, Juan would have to be placed on two (2) different medications, and suffer a detrimental reaction to these drugs or show no signs of improvement."[4]
- "AEtna's decision to refuse his prescription for Vioxx was final . . ."[5]

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1 Plaintiff's Original Petition, p. 4.

2 Plaintiff's Original Petition, p. 4.

3 Plaintiff's Original Petition, p. 4 (emphasis in original).

4 Plaintiff's Original Petition, p. 4.

5 Plaintiff's Original Petition, p. 4.

- Juan Davila suffered damages "[a]s a result of AEtna's delaying the prescription of Vioxx . . ."[6]

Because Section 502(a) of ERISA provides the exclusive remedies for the wrongful denial of plan benefits as alleged by Plaintiff, Plaintiff's state law claims are completely preempted and removable to this Court. *See Cristantielli v. Kaiser Foundation Health Plan of Texas*, 113 F. Supp. 2d 1055, 1065 (N.D. Tex. 2000) (finding claims that HMO failed to authorize timely and/or proper diagnostic testing and examination fall within Section 502(a) and are completely preempted because the plaintiffs' complaint actually centers around the denial of benefits); *see also McClelland v. Gronwaldt*, 155 F.3d 507, 512 n.15 (5th Cir, 1998) *quoting Anderson v. Electronic Data Systems Corp.*, 11 F.3d 1311, 1315 (5th Cir. 1994) ("'Congress may so completely preempt a particular area that any civil complaint raising the select group of claims is necessarily federal in character' and the case may be removed even if no federal claim is asserted in the complaint and federal preemption, raised as a *defense*, is the only issue of federal law implicated in the case.")

V.

Additionally, Plaintiff's claims are completely preempted even though he attempts to assert negligence claims under the Texas Health Care Liability Act ("THCLA"). *See Cristantielli*, 113 F. Supp. 2d at 1064-65. The allegedly wrongful conduct of denying benefits for Vioxx was a coverage determination made by Aetna U.S. Healthcare of North Texas, Inc. in its role of providing claims administrative services to the Monitronics Plan. Indeed, state law claims based on plan administration, including coverage determinations or utilization review, are preempted by ERISA. *See Corporate*

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6 Plaintiff's Original Petition, p. 5.

Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526, 534 (5th Cir.), *pet. filed*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665) (state efforts to regulate the administrative activities of an HMO—*i.e.*, activities such as "determining eligibility and *coverage*"—are preempted by ERISA and are not encompassed by the THCLA in any event). This is true even when the Plaintiff contends his treating physician recommended treatment that was determined not to be covered under the employee benefit plan. *See Corporate Health*, 220 F.3d 641, 643-44 (denying State's motion for rehearing) (state law claims for allegedly wrongful determinations that treatment is not medically necessary are preempted). Moreover, given their true nature, Plaintiff's claims "for negligence are appropriately recharacterized as claims for benefits and therefore fall within the complete preemption of ERISA." *Cristantielli*, 113 F. Supp. 2d at 1065-66.

VI.

The Affidavit of Joseph Lopez, M.D., attached as Exhibit A to Plaintiff's Petition, further demonstrates that the wrongful acts allegedly committed by Aetna constitute plan administration. Specifically, the Affidavit shows that Plaintiff is complaining about the denial of a request for benefits under the Plan, for which the civil enforcement provisions of ERISA provide the exclusive remedies:

> Aetna refused to fill [Mr. Davila's] prescription. After I contacted Aetna regarding its refusal, Aetna sent me a letter [which read], 'Aetna . . . conducts a utilization review program . . . . A request for authorization of coverage of the drug Vioxx has been reviewed. The member's benefit design requires precertification for this drug in the Aetna U.S. Healthcare Medication Formulary Guide. . . [Y]our request to authorize payment for the [drug] has been denied.' . . . [The] formulary policies . . . resulted in the gastrointestinal injury to Mr. Davila.[7]

Accordingly, this Court has original jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e) and the matter is one that may be removed pursuant to 28 U.S.C. § 1441(a) and (b) and controlling case law. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (holding state court action asserting only state law causes of action relating to alleged failure to pay a claim for benefits under an employee benefit plan constitutes a federal question and is removable to federal court); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324-25 (5th Cir. 1992) (removal allowed and preemption found where day home nursing care was ordered instead of hospitalization as a result of alleged cost-containment utilization review regime); *see also Corporate Health*, 220 F.3d at 644-45 (reaffirming its preemption analysis in Corcoran).

VII.

Promptly after fling this Notice of Removal, written notice thereof will be given to Plaintiffs and a copy of this Notice of Removal will be filed with the District Clerk of Tarrant County, Texas, as provided by law. (A true and correct copy of the Notice being filed with the District Clerk of Tarrant County, Texas is attached as Exhibit 5).

VIII.

For the foregoing reasons, Aetna prays that the State Court Action be removed to the United States District Court for the Northern District of Texas. Dallas Division.

---

[7] Exhibit A to Plaintiff's Original Petition (quoting a letter of May 10, 2000 attached as Exhibit A-2 to the Petition).

Respectfully submitted,

By:_____/s/_____
John B. Shely
Attorney-in-Charge
State Bar No. 18215300
ANDREWS & KURTH L.L.P.
600 Travis Street, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4105
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David Broiles
State Bar No. 03054500
500 Main Street, Suite 1200
Fort Worth, Texas 76102
Telephone: (817) 335-3311
Facsimile: (817) 335-7733

ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been delivered to the following counsel by certified mail, return receipt requested, no. Z 330 913 329 on the 12th day of December, 2000:

Mr. George Parker Young
Friedman, Young, Suder & Cooke
P.O. Box 2508
Fort Worth, Texas 76113

_____/s/_____
John B. Shely

APPENDIX K

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT

This is a **Group Agreement** between Aetna U.S. Healthcare of North Texas Inc. (hereinafter referred to as "**HMO**") and Monitronics International Inc (hereinafter referred to as "**Contract Holder**").

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the terms, conditions, rights, and privileges as set forth in this **Group Agreement** and the Certificate of Coverage. **Members** covered under this **Group Agreement** are subject to all the conditions and provisions contained herein.

This **Group Agreement** is governed by applicable federal law and the laws of Texas.

If any provision of this **Group Agreement** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect. In consideration of the Premium payments made by or on behalf of the **Contract Holder**, **HMO** shall provide coverage for those services described in the Certificate of Coverage subject to the terms and conditions set forth in this **Group Agreement** and the Certificate of Coverage (herein after referred to as "**Certificate**") which is attached to this **Group Agreement**, and fully incorporated herein by reference. The terms and conditions used in this **Group Agreement** have the same meaning given

those terms in the Certificate unless otherwise specifically defined in this **Group Agreement**.

Group Agreement Effective Date: December 1, 1999
Contract Holder Number: 148028

PREMIUMS

A. **Premiums** for the **Covered Benefits** under this **Group Agreement** are set forth in the Cover Sheet attached hereto, which is fully incorporated herein by reference.

B. The **Premiums** set forth in the Cover Sheet shall be effective for the initial term of this **Group Agreement**. Thereafter, if **HMO** gives a minimum of 30 days prior written notice to the **Contract Holder**, **HMO** may change the **Premiums**:

- upon the renewal date of this **Group Agreement**; or
- upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to **Members**.

Payment of the applicable **Premium** on and after that date shall constitute acceptance of those changes by the contract Holder, individually and on behalf of all **Members** enrolled under this **Group Agreement**.

C. **Premiums** are payable to **HMO** on or in advance of each **Premium** due date at the corporate offices of **HMO** unless otherwise specified by **HMO** in writing. The payment of any **Premium** shall not maintain coverage under this **Group Agreement** in force beyond the date when the next payment becomes due; however, a 31 day grace period, during which time this **Group Agreement** will remain in force, shall be granted for payment of each amount due after the first. The **Contract Holder** shall remain liable for the payment of the **Premium** for the time

coverage was in effect during the grace period and the **Member** shall remain liable for **Copayments** owed. A check is not a payment until it is honored by a bank. **HMO** reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

D. Retroactive adjustments to the **Contract Holder's** billings may be made by **HMO** for the termination of **Members** not posted to previous **Contract Holder** billings. However, the **Contract Holder** may only receive a maximum of 2 month's credit for Member terminations which occurred more than 31 days prior to the date **HMO** was notified of such termination by the **Contract Holder**. Retroactive additions will be made at the discretion of **HMO** based upon eligibility guidelines, as detailed in the **Certificate** and on the Schedule of Benefits, and are subject to the payment of all applicable **Premiums**. As between **HMO** and the **Contract Holder**, the **Contract Holder** shall be responsible for any claims paid by **HMO** with respect to a **Member**, to the extent **HMO** relied on the **Contract Holder's** submitted enrollment to confirm coverage where coverage was not valid.

E. **Premiums** shall be paid in full for **Members** whose coverage is effective on the **Premium** due date or whose coverage terminates on the last day of the **Premium** period.

F. If the **Premiums** are not paid by the **Premium** due date, **HMO** will require the **Contract Holder** to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the 31st day after the **Premium** due date.

In the event of non-payment of any amount due, **HMO** shall be entitled to all remedies prodded for in law or in equity.

ENROLLMENT

Enrollment for eligible individuals, as described in the **Certificate**, will be permitted during the **Open Enrollment Period**, or within 31 days from the date the individual and any dependent becomes eligible for coverage. Completed enrollment information must be submitted to the **Contract Holder** for transmittal to **HMO**. Eligible individuals and any eligible dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment**. Coverage shall not become effective until confirmed by **HMO**. The **Open Enrollment Period** shall be consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit representatives of **HMO** to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure.

There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the Schedule of Benefits.

The eligibility of the group, the composition of the group and the eligibility requirements used to determine membership in the group which exist at the effective date of this **Group Agreement** are material to the execution of this **Group Agreement** by **HMO**. The **Contract Holder** shall not during the term of this **Group Agreement** modify the **Open Enrollment Period**, the waiting period as described on the Schedule of Benefits, or any other eligibility requirements as described in the **Certificate** and on the Schedule of Benefits, for the purposes of enrolling the **Contract Holder's** eligible

individuals and dependents under this **Group Agreement**, unless agreed to in writing by **HMO**.

CONTRACT HOLDER TERMINATION

A. This **Group Agreement** map be terminated the **Contract Holder** on any **Premium** due date by giving 60 days' prior written notice.

B. The **Contract Holder** may terminate this **Group Agreement** as of its renewal date, by providing **HMO** written notice of non-renewal not less than 60 days prior to the renewal date.

C. The **Contract Holder** may terminate this **Group Agreement** as of the date any Premium change would become effective, by providing **HMO** with written notice of termination not less than 30 days prior to such effective date.

D. **HMO** may terminate or non-renew the **Group Agreement** if:

1. **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Group Agreement** within the grace period. **HMO** may terminate this **Group Agreement** as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Group Agreement** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period;

2. the **Contract Holder** has performed an act or practice that constitutes fraud or intentional misrepresentation of a material fact in obtaining coverage under this **Group Agreement**;

3. The **Contract Holder** has failed to comply with a material plan provision relating to any employer

contribution or group participation rules, under applicable state or federal law;

4. **HMO** ceases to offer coverage in the market in accordance with state law;

5. **HMO** ceases to offer coverage of a specific product in the market in accordance with state law;

6. the **Contract Holder** no longer has any enrollee under the plan who lives, resides, or works in the **Service Area**;

7. the **Contract Holder's** membership in the association, through which coverage is obtained, ceases.

E. Upon thirty days written notice to the **HMO**, the **Contract Holder** may terminate this **Group Agreement** in the case of a material change by the **HMO** to any provisions required to be disclosed to the **Contract Holder** or **Members** pursuant to State law.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Group Agreement**.

No change in the eligibility or participation requirements of the **Contract Holder** shall be permitted to affect eligibility or enrollment under this **Group Agreement** unless such change is agreed to by **HMO** and the **Contract Holder**, and is not otherwise contrary to applicable state or federal laws, rules or regulations. Breach of this provision is considered a material breach of this **Group Agreement** and may be the basis for termination by giving 60 days' prior written notice. It is the responsibility of the **Contract Holder** to notify the Subscribers of the termination of the **Group Agreement** in compliance with all applicable laws. However, **HMO** reserves the right to notify **Subscribers** of termination of the

Group Agreement for any reason, including non-payment of **Premium**.

In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

INDEPENDENT CONTRACTOR RELATIONSHIPS

A. Between **Participating Providers** and **HMO**.

The relationship between **HMO** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **HMO** nor is **HMO** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.

B. Between the **Contract Holder** and **HMO**.

The relationship between **HMO** and the **Contract Holder** is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this **Group Agreement**.

ADMINISTRATION OF THE AGREEMENT

HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Group Agreement**.

A. Entire Agreement.

This **Group Agreement**, including the Group Application, Cover Sheet, Certificate of Coverage, Schedule of Benefits, any Riders, and any amendments, endorsements, inserts or attachments, constitutes the entire **Group Agreement** between the **Contract Holder** and **HMO**, and on the **Effective Date of Coverage**, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by **HMO** for **Covered Benefits** provided by this **Group Agreement**.

All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **HMO** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

B. Amendments.

This **Group Agreement** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **HMO**, and this **Group Agreement** shall be deemed to be amended to conform therewith at all times. This **Group Agreement** may be changed at any time for any other reason by agreement between **HMO** and the **Contract Holder**, without the consent of any employee, **Member**, or other person. Except as detailed below, any amendments to this **Group Agreement** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **HMO**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **HMO** by making any other

commitment or representation or by giving or receiving any information. No change in this **Group Agreement** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **HMO**.

Formal acceptance of an amendment to this **Group Agreement** by the **Contract Holder** shall not be required if:

1. the change was requested by either the **Contract Holder** or **HMO** and is agreed to in writing by the other; or
2. the change is required to bring the **Group Agreement** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Group Agreement** is delivered; or
3. the **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

C. Forms.

HMO shall supply the **Contract Holder** with a reasonable supply of its forms and descriptive literature. The **Contract Holder** shall distribute **HMO's** forms and descriptive literature to any eligible individual who becomes eligible for coverage. The **Contract Holder** shall, within 20 business days of receipt from an eligible individual, forward all applicable forms and other required information to **HMO**.

D. Records.

HMO shall maintain **Member** records. The records will contain key facts about the **Member's** coverage. Each month during the period of this **Group Agreement**, on forms approved by **HMO**, the **Contract Holder** shall furnish to **HMO** such information as may

reasonably be required to administer the **Group Agreement**. This includes, but is not limited to, information needed to enroll **Members** of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**. **HMO** shall not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **HMO**.

The **Contract Holder** shall make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **HMO** for inspection, at **HMO's** expense, at the **Contract Holder's** office, during regular business hours, upon reasonable advance request from **HMO**. This provision shall survive the termination of this **Group Agreement** as necessary to resolve outstanding financial or administrative issues pursuant to this **Group Agreement**.

E. Clerical Errors.

Incorrect information furnished to **HMO** may be corrected, provided that **HMO** has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if **HMO**, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to **Members**. Upon discovery of such errors or delay, an adjustment of **Premiums** shall be made. In no case will adjustments in coverage or **Premiums** be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested addition, deletion, or change in coverage.

F. Claim Determinations.

HMO has complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **HMO** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this **Group Agreement**. **HMO** shall be deemed to have properly exercised such authority unless **HMO** abuses its discretion by acting arbitrarily and capriciously.

G. Fraudulent or Intentional Misrepresentations.

If any relevant fact as to a **Member** is found to have been misrepresentation, an equitable adjustment of **Premiums** may be made. If the misrepresentation affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force.

H. Incontestability.

Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

1. No statement made by the **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
2. No statement made by the **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for 2 years from its effective date.
3. No statement made by a **Member** shall be used in defense of a claim for loss incurred or commencing after coverage has been in effect for 2 years.

I. Assignability.

No rights or benefits under this **Group Agreement** are assignable by the **Contract Holder** to any other party unless approved by **HMO**.

J. Waiver.

HMO's failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **HMO's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

K. Notices.

Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or Cover Sheet, or to any more recent address of which the sending party has received written notice.

L. Third Parties.

This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

M. Non-Discrimination.

The **Contract Holder** agrees to offer participation in **HMO** to all persons as described in the Subscriber Eligibility section of the Schedule of Benefits under terms and conditions no less favorable than those for any alternate health benefit plans. The **Contract Holder** agrees

to make no attempt, whether through differential **Contract Holder Premium** contributions or otherwise to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

N. Execution of this Agreement.

This **Group Agreement** shall be executed by **HMO** and the **Contract Holder** once the Group Application, which is attached hereto and fully incorporated herein by reference, is completed and signed. However, payment of the applicable Premium on and after the effective date of this **Group Agreement** shall constitute execution of this **Group Agreement** by the **Contract Holder**.

O. Inability to Arrange Services.

In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **HMO's Participating Providers** or entities with whom **HMO** has arranged for services under this **Group Agreement**, or similar causes, the rendition of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

P. Use of the HMO Name and all Symbols, Trademarks, and Service Marks.

HMO reserves the right to control the use of its name and all symbols, trademarks, and service marks presently

existing or hereinafter established with respect to it. The **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of **HMO** and will cease any and all usage immediately upon request of HMO or upon termination of this **Group Agreement**.

Q. Worker's Compensation.

The **Contract Holder** is responsible for protecting **HMO's** interests in any workers compensation claims or settlements with any eligible individual. **HMO** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

At the signing of this **Group Agreement** and upon renewal, the **Contract Holder** shall submit proof of their worker's compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Worker's Compensation. The **Contract Holder** is also required to submit a monthly report to **HMO** listing all worker's compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individual.

R. Conflict Between **Group Agreement** and **Certificate**

Any direct conflict between the **Group Agreement** and the **Certificate** will be resolved according to the terms which are most favorable to the **Subscriber**.

APPENDIX L

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)
2777 Stemmons Freeway, Suite 400
Dallas, Texas 75207
214-200-8000 or 1-800-992-7947

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna U.S. Healthcare of North Texas Inc., hereinafter referred to as HMO, and the Contract Holder. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

The Group Agreement under which this Certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THE GROUP AGREEMENT AND THE CERTIFICATE OF COVERAGE CONTAIN NO ARBITRATION PROVISION.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact HMO's Member Service Department at 1-800-992-7947.

You may call HMO's toll-free telephone number for information or to make a complaint at 1-800-992-7947

You may also write to HMO at:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact HMO first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener information o para someter una queja:

Puede comunicarse con su HMO Member Service Department al 1-800-992-7947.

Usted puede llamar al numero de telefono gratis de (company)'s para information o para someter una queja al 1-800-992-7947

Usted tambien puede escribir a HMO:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTES SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el HMO primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER:

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-228-1570.

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS:

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-228-1570.

Su queja sera referida a la agencia estatal que regula el hospital o centro de tratamiento para la dependencia quimica.

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HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access Covered Benefits as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf if a **Member** does not select a **PCP** at the time of enrollment, the **HMO** will assign a **PCP** to the **Member**. The **Member** retains the right to reject the **PCP** assigned the **Member** however the **Member** must select another **PCP** at the time of rejection. The **HMO** will, in good faith, assign a **PCP** located near to a **Member's** residence or place of employment.

A **Member** who has been diagnosed with a chronic, disabling or life threatening illness may apply to the **HMO's** Medical Director to be able to select a **Participating Specialist** as the **Member's PCP**. The **HMO** will specify to the **Member** the information necessary, including certification of the medical need, and signatures of the **Member** and the **Participating Specialist** interested in serving as the **Member's PCP**. The **Participating Specialist** must meet the **HMO's** requirements for **PCP** participation and be willing to accept the coordination of all the **Member's** healthcare needs. The designation of the **Participating Specialist** as the **Member's PCP** will not be retroactive. If the request for special consideration of a **Participating Specialist** is denied, a **Member** may appeal the decision through the **HMO's** established Grievance/Complaint Procedure.

B. **The Primary Care Physician.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

Should **Medically Necessary** covered services be unavailable through a **Participating Provider**, upon the request of the **Primary Care Physician** or **Participating Provider** and with prior approval of the **HMO**, a **Referral** may be made to a non-**Participating Provider** for those **Medically Necessary** covered services.

The **HMO** will allow for a review by a **Specialist** of the same or similar specialty as the type of **Physician** or **Provider** to whom the **Referral** was requested prior to the **HMO's** approval of the **Referral**.

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Pro-**

vider contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**.

D. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the **Member** Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request. The **Member** may change their **PCP** up to four times in a twelve month period.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination.

F. **Provider Communication.**

HMO will not prohibit, attempt to prohibit or discourage any **Health Professional** from discussing or communicating to a **Member** or a **Member's** designee any information or opinions regarding the **Member's** health care, any provisions of health care plan as it relates to the medical needs of the **Member** or the fact

that the **Health Professional's** contract with the **HMO** has terminated or will no longer be providing services under the **HMO**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

   b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, and dependents of dependents) who meets the eligibility requirements described on the Schedule of Benefits.

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services. Submission of complete enrollment information and **Premium** payment to **HMO** must be made within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

   An eligible individual and any eligible dependents who are eligible may enroll.

2. Open Enrollment Period

   Eligible individuals or any dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

      A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, notification of the birth and any required additional **Premium** must be received by **HMO** not later than the 31st day after the date of birth. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

      The coverage for newly born; adopted children and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

   b. Adopted Children.

      A legally adopted child, a child for whom a **Subscriber** is a court appointed legal guardian, or a child for which the **Subscriber** is a party in a suit in which the adoption of the child by the

Subscriber is sought, and who meets the definition of a **Covered Dependent**, will be treated as a dependent. The **Subscriber** must make a written request for coverage within 31 days of the date the adoption is final or the legal guardianship has been decreed, or within 31 days after the **Subscriber** is a party in a suit for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The coverage shall be comparable to the coverage provided to other **Covered Dependents**. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility as defined on the Schedule of Benefits; Dependent Eligibility In order to continue coverage for a handicapped child, the **Subscriber** must provide proof of the child's incapacity and dependency to **HMO** within 31 days of the date the child attains the limiting age. Subsequent proof may be requested by the **HMO**, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such coverage. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to

HMO that a dependent meets the eligibility requirements described in this **Certificate**.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent's covered under another group health plan or self-funded employer health benefit plan when initially eligible for coverage under **HMO**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO** during the initial eligibility stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or self-funded employer health benefit plan for one of the following reasons:

   i. termination of employment; or
   ii. reduction in the number of hours of employment; or

   iii. termination of contributions toward the premium made by the employer, or
   iv. death of a spouse or divorce; or

   Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the **HMO Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

   The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

   The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or pre-existing condition provision described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a

Covered Benefit under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physi-**

cian's office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient Hospital Services; and

- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member services 800 telephone number listed on the **Member's** identification card

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.

2. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

   a. call the **PCP's** office; and

   b. identify himself or herself as a **Member;** and

   c. follow the **PCP's** or covering **Physician's** instructions.

   If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care Benefits section of this **Certificate**.

3. Hospital visits.

4. Periodic health evaluations to include:

   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus; influenza type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law.

   b. routine physical examinations.

   c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

   d. routine speech and hearing screenings.

   e. immunizations (but not if solely for the purpose of travel or employment).

   f. routine vision screenings.

5. Injections, including allergy desensitization injections.

6. Casts and dressings.

7. Health Education Counseling and Information.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.

2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 and older, one routine mammography every year; or
- when **Medically Necessary**.

3. prostate cancer screening, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from his **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit

Prostate Cancer Screening benefits for male **Members** are provided as follows:

- age 40-49, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year, if the **Member** is at an increased risk of developing prostate cancer as determined by his physician; or
- age 50 and older, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.

- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. Open access includes care related to pregnancy; care for-all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition which is within the scope of the professional OB/GYN practice. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:

1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers**.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area**

unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at participating **Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is prodded for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

   If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a **Physician**, registered nurse, or

other appropriate licensed health care **Provider** and may be provided at the mother's home, a health care **Provider's** office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A **Copayment** will not apply for home health care visits.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a **Member** following a mastectomy:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a mastectomy;
2. a minimum of 24 hours of inpatient care in a **Participating Hospital** following a lymph node dissection for the treatment of breast cancer.

A **Member** may request a shorter length of stay if the **Member's Participating Provider** determines the shorter stay to be appropriate.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically ap-

proved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Chemical Dependency Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification** and treatment of **Chemical Dependency**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or a controlled substance.

2. Inpatient care benefits in a **Participating Hospital** or treatment facility that is a **Participating Provider** are covered for the medical complications and treatment of **Chemical Dependency** and **Detoxification**. Benefits include medical treatment and referral services for **Chemical Dependency** or addiction. The following services shall be covered under inpatient

treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray, psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

J. **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers**.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. Benefits for **Serious Mental Illness**

Inpatient care received in a participating **Hospital** or **Participating Mental Health Treatment Facility** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** while the **Member** is a full-time inpatient is covered. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Outpatient care received from a **Participating Provider** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** is covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Any outpatient visits for the purpose of medication management will not be counted toward the maximum number of visits, and visits for medication management will be under the same terms and conditions as for outpatient visits for treatment of physical illness generally.

Coverage for **Serious Mental Illness** will include the same **Copayments** as for any other physical illness.

K. **Emergency Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**.

   Benefits include:

   a. a medical screening examination/evaluation, in accordance with any State or Federal law, the purpose of which is to determine whether an emergency medical condition exists;

   b. the treatment and stabilization of the **Member** for the emergency medical condition;

   c. services originating in a **Hospital** emergency facility or comparable facility following treatment or stabilization of an emergency medical condition, as approved by **HMO**. In addition, the **HMO** reserves the right to approved or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-**Participating Provider** located either within or outside the **HMO Service Area**, for those expenses,

less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

2. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received

L. **Rehabilitation Benefits.**

A **Member** is covered for rehabilitation, services, and therapies benefits that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

M. **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Preauthorization must be obtained from the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.
3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Physical, speech and hearing, or occupational therapy is covered.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or

legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

O. **Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

P. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe

federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ.

S. **Diabetes Related Benefits.**

Benefits for the treatment of diabetes and associated conditions. Coverage includes diabetes equipment, diabetes supplies and diabetes self-management training. All provisions applicable to other illness and surgical treatment, including **Copayments**, will apply to benefits for diabetes related coverage.

T. **Additional Benefits.**

Durable Medical Equipment Benefits. Durable Medical Equipment will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary** Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy.

- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibulopiasty treatment of periodontal disease, and dental implants are not covered. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts. Dental services and supplies for treatment of temporomandibular joint (TMJ) dysfunction except for diagnostic and medical/surgical treatment of TMJ.
- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances,

improvements made to a **Member's** house or place of business, and adjustments made to vehicles.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- **Experimental** or **Investigational Procedure**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or Investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- False teeth.
- Hair analysis.

- Health services, specifically charges for health services, incurred before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**. This does not include covered services resulting from complications of pregnancy incurred after the **Member's** effective date.
- Hearing aids.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools.
- Hypnotherapy, except when specifically approved by **HMO**.
- Implantable drugs.
- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg program or gestational carriers. This exclusion does not apply to artificial insemination, **Medically Necessary** services to diagnose and treat the underlying medical cause of **Infertility**, or donor sperm.
- Inpatient care for **Serious Mental Illness** which is not provided in a **Hospital** or **Mental Health Treatment Facility**; non-medical ancillary services and long-term rehabilitation services for **Serious Mental Illness**.

- Inpatient treatment for **Mental or Behavioral Conditions** unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
- Non-medically necessary services, including but not limited to, those services and supplies:
  1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  2. that do not require the technical skills of a medical, mental health or a dental professional;
  3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.

- Outpatient prescription or non-prescription drugs and medicines unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips, except that this exclusion does not apply to diabetes supplies.
- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private duty or special nursing care, unless preauthorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship, counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be trade.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  2. needles, syringes and other injectable aids, except that this exclusion does not apply to diabetes supplies;

  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex. regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but

is not covered for a particular disease or injury under such law. that disease or injury will be considered "non-occupational" regardless of cause.

- Treatment of spinal disorder services, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or when it is a direct access benefit.
- Vision care services and supplies.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Services related to the care, filling, removal or replacement of impacted teeth.

B. **Limitations.**

In the event there are two or more alternative Medical Services which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly Medical Service, as determined by **HMO**, provided that **HMO** approves coverage for the Medical Service or treatment in advance.

Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of

this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA, however may be eligible for continuation of coverage as provided by subsection B of this section. Continuation of Coverage—State of Texas.

1. Minimum Size of Group:

   The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or

   b. **Subscriber's** death, or

   c. **Subscriber's** entitlement to Medicare benefits, or,

   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

   The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

   e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

   f. the date the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

   a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

   b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Member's** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6 Responsibility to provide **Member** with notice of Continuation Rights:

   The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

   Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract**

Holder and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage—State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

a. the death of the **Subscriber**,

b. the retirement of the **Subscriber**, or

c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid

Continuation of coverage under this section will terminate on the earliest to occur of:

a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;

b. the end of the 3 year period after the date of the divorce or legal separation;

c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. Group Continuation Privilege.

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder**

within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

a. six months after the date the election is made;

b. the date on which failure to make timely payments would terminate coverage;

c. the date on which the group coverage terminates in its entirety;

d. the date on which the **Member** is or could be covered under Medicare;

e. the date on which the **Member** is covered for similar benefits by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;

f. the date the **Member** is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

C. **Conversion Privilege.**

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA or state law, benefits as described in the COBRA Continuation Coverage or Continuation of Coverage—State of Texas sections of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of good health provided that **Member's** coverage under this **Certificate** terminated for one of the following reasons:

a. Coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder;** or

b. The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate**, in which case the **Subscriber** and **Subscriber's** depend-

ents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert; or

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age; or

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without punishing evidence of good health. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

D. **Extension of Benefits While Member is Receiving Inpatient Care.**

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay; or
2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached; or
4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or
5. 12 months from the termination date of the **Group Agreement**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

GRIEVANCE/COMPLAINT PROCEDURE

In situations when **Members** are dissatisfied with **HMO** services, the following procedures govern complaints, grievances, and grievance/complaint appeals made or submitted by **Members**. These complaints, grievances and grievance/ complaint appeals will be handled in a timely manner.

A. **Definitions.**

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancella-

tions, terminations or renewals, and the quality of services provided. **HMO** encourages **Members** to resolve an individual inquiry without the initiation of a Grievance/Complaint Review.

2. A "grievance/complaint" is any dissatisfaction expressed by a **Member** orally or in writing to **HMO** with any aspect of **HMO's** operation, including but not limited to:

   a. dissatisfaction with plan administration;

   b. appeal of an adverse determination;

   c. the denial, reduction, or termination of a service;

   d. the way a service is provided; or

   e. disenrollment decisions.

   A grievance/complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the **Member**.

B. **Grievance/Complaint Review.**

   1. **HMO** will send the **Member** acknowledgment of the grievance/complaint within 5 business days of having received it. The acknowledgment will contain:

      i. the date of receipt of the grievance/complaint;

      ii. a description of **HMO's** grievance/complaint procedures and time frames;

      iii. a one-page complaint form, clearly stating that the grievance/complaint form must be returned to **HMO** for prompt resolution of the grievance/complaint, if the grievance/complaint is received orally;

      iv. requests for the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance/complaint; and

      iii. a notice informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance/complaint process.

   HMO will acknowledge, investigate, and resolve the grievance/complaint within 30 calendar days from the date of receipt of the written grievance or one-page grievance/complaint form.

   2. The Grievance/Complaint Panel deciding the grievance/complaint shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance/complaint.

   3. A written notice stating the result of the review by the Grievance/Complaint Panel shall be forwarded by **HMO** to the **Member**. Such notice shall include:

      a. a description of the Panel's understanding of the **Member's** grievance/complaint as presented to the Grievance/Complaint Panel (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

      b. the Panel's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical

report, the services were not covered by the **Certificate**, etc.); and

c. citations to the evidence or documentation used as the basis for the decision, including the specialization of any **Provider** consulted (i.e., reference to the **Certificate**, medical records, etc.);

d. if the decision is to deny services based on an adverse determination of **Medical Necessity**, the clinical bases used to reach that decision;

e. that the decision of the Grievance/Complaint Panel shall be final and binding unless appealed by the **Member** to **HMO** within sixty (60) days of the date of the notice of the decision of the Grievance/Complaint Panel; and

f. a full description of the appeals process and the time frames for the final decision on the appeal.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by the Appeal Panel, **HMO** shall provide the **Member** filing the appeal with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the **Member** to appear before the Appeal Panel. The appeal process gives the **Member** the opportunity to appear in person before the Appeal Panel or address the **Member's** issues through a written appeal to the Appeal Panel. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

   No less than 5 business days prior to the **Member's** appearing before the Appeal Panel, the **Member**

will receive a copy of any documentation to be presented by the **HMO** staff; the specialization of **Physicians** or **Providers** consulted during the review, and the name and affiliation of all **HMO** representatives on the Appeal Panel. The **Member** may respond to this information for the Appeal Panel to consider in the **HMO's** deliberations.

2. The Appeal Panel shall be established by the Board of Directors of the **HMO** and shall be comprised of equal numbers of non-employee **HMO Members**; **HMO** staff persons not previously involved in the disputed decision; and **Physicians** or **Providers** experienced in the area of care that is in dispute and who are independent of the **Physicians** or **Providers** who made the prior decision that resulted in the **Member's** appeal. If specialty care is in dispute, the appeal panel must include an additional person who is a **Specialist** in the field of care to which the appeal relates.

3. The Appeal Panel shall hold appeal hearings within the **Members** county of residence or the county where the **Member** normally receives the **HMO's** health care services. Another location may be used if in agreement by the **Member** and **HMO**.

4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to pre-

sent witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance/Complaint Appeal Panel shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

5. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Panel shall have the right to exclude redundant testimony or excessive argument by any party or witness.

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Appeal Panel shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.

8. The Appeal Panel shall render a written decision within 30 days of the conclusion of the appeal hearing. The decision shall contain:

   a. date of receipt of the oral or written request for appeal;

   b. a statement of the Appeal Panel's understanding of the nature of the grievance/complaint and the material facts related thereto;

   c. the Appeal Panel's decision and rationale, including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision;

   d. a summary of the evidence, including necessary document supporting the decision; and

   e. a statement of the **Member's** right to appeal to the Department of Insurance, with the following toll-free telephone number and complete address of the Department of Insurance:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714 – 9104
1 - 800 - 252 - 3439.

D. **Ongoing Emergency or Denial of Continued Stays for Hospitalization Appeals.**

Investigation and resolution of appeals related to ongoing emergencies or denials of continued stays for hospitalization grievances will be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed 1 business day from the **Member's** request for appeal.

Due to the ongoing emergency or continued hospital stay, and at the **Member's** request, **HMO** shall provide, in lieu of a grievance/complaint appeal panel, a review by a **Provider** not previously involved with the prior decision and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal. The **Provider** reviewing the appeal may interview the **Member** or the **Member's** designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within 3 days.

E **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Department of Insurance or
2. the filing of a complaint with the Department of Insurance; or
3. the establishing of any litigation or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **Certificate** by **HMO**, or any matter within the scope of the grievance/ complaint resolution process of any complaint, grievance or grievance appeal.

F. **Record Retention.**

HMO shall retain the records of all grievances/complaints for a period of at least 7 years from the date of the receipt of the grievance/complaint. The records will include each grievance/complaint and any grievance/complaint proceeding and any actions taken on a grievance/complaint. A **Member** is entitled to a copy of the record on the applicable grievance/complaint and any grievance/complaint proceeding.

G. **Independent Review Organization (IRO).**

A **Member** whose appeal of an adverse determination is denied by **HMO** has the right to seek review of that determination by an IRO assigned to the appeal in accordance with state law. Not later than the third business day after the date that **HMO** receives a request for review, **HMO** will provide to the IRO the following:

1. any medical records of the **Member** that are relevant to the review;

2. any documents used by **HMO** in making the determination;
3. the written notification of the Appeal Hearing decision provided to the **Member;**
4. any documentation and written information submitted to **HMO** in support of the appeal; and
5. a list of each **Provider** who has provided care to the **Member** and who may have medical records relevant to the appeal.

HMO will comply with the IRO's determination with respect to the **Medical Necessity** or appropriateness of health care items and services for a **Member**, and pay for the independent review.

In a circumstance involving a **Member's** life-threatening condition, the **Member** is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of **HMO's** adverse determination. A life-threatening condition is a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

H. **Fees and Costs.**

Nothing herein shall be construed to required **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance/complaint or appeal.

I. **HMO** may not refuse to renew or cancel coverage of the **Contract Holder** or a **Member** or take any other retaliatory action because the **Contract Holder** or a **Member** has filed a grievance/complaint or appealed a decision made by **HMO**. Also, **HMO** may not refuse to renew or terminate a contract with a **Participating Provider** or **Participating Physician** in retaliation for the fil-

ing of a grievance/complaint or appeal of a decision made by **HMO**, on behalf of the **Contract Holder** or a **Member**.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**.

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the fast rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   1. secondary to the plan covering the person as a dependent; and

   2. primary to the plan coveting the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   1. covers the person as other than a dependent; and

   2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

   1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

   2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   3. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers

the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or
2. the dependent of such person,

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or
2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision as permitted by State or Federal law.

Other plan means any other plan of health expense coverage under:

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional "fault" auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The

reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an Allowable Expense unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that

excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determines its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

Medicare benefits will be taken into account for any **Member** who is eligible for Medicare. This will be done whether or not the **Member** is enrolled in Medicare.

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Dependents** who are eligible for Medicare. When a active **Sub-**

scriber, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Retired Employees and Their Dependents Who Are Eligible For Medicare.

If the eligible class of employees of this **Certificate** includes coverage for retired employees who are eligible for Medicare, the benefits provided by this **Certificate** will be paid in accordance with the Provision for Coordination with Medicare section below.

Provision for Coordination with Medicare.

Benefits under this **Certificate** will cease for any **Member** eligible for Medicare. If coverage would cease because a **Subscriber** is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's

Compensation) any benefits in force for the **Subscriber's Covered Dependents** may be continued. Coverage will then continue until it terminates for some other reason under the rules of this **Certificate**. A conversion privilege may be available in the event that a **Dependent's** coverage under this **Certificate** ends because the **Subscriber** becomes eligible for Medicare. This does not apply if the **Member** is eligible for any Medicare related benefits under this **Certificate**.

SUBROGATION

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which the third party is or may be responsible. **HMO** receives all rights of recovery acquired by a **Member** against any person or organization for negligence or any willful act resulting in illness or injury covered by the **HMO Covered Benefits**, but only to the extent of these **Covered Benefits**. Upon receiving such **Covered Benefits** from the **HMO**, the **Member** has considered to have assigned such rights of recovery to the **HMO** and to have agreed to give the **HMO** any reasonable help required to secure the recovery. The recovery may include attorney fees and court costs if applicable.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive

pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**.

B. **Reports and Records. HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating**

Provider. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**.

No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any

Participating Provider or other **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all Medical Services which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

   a within thirty days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the **Provider** Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities

who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from

any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. During the first two years, coverage can be voided for material misrepresentation contained in a written application. After two years, coverage can be voided only in the event of a fraudulent misstatement contained in the written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any

information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. If this **Certificate** contains any provision not in conformity with Texas state law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be actively at work on a non-scheduled work day only if such person is actively at work on the last regularly scheduled work

day immediately preceding such non-scheduled work day.

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Behavioral Health Provider**. A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Certificate**. This **Certificate** of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Chemical Dependency**. The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.
- **Chemical Dependency Rehabilitation.** Services, procedures and interventions to eliminate the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance, according to individualized treatment plans.
- **Contract Holder**. An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment**. A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.
- **Copayment** Maximum. The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery**. Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty

and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Covered Dependent**. Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.
- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has

reached the maximum level of physical or mental function and such person is not likely to make further significant improvement **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Detoxification**. The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment**. Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures**. Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
2. required FDA approval has not been granted for marketing; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or

6. it is not ger rally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or

7. it is provided or performed in special settings for research purposes.

- **Group Agreement**. The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals**. A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or **Certificate**.

- **HMO**. Aetna U.S. Healthcare of North Texas Inc., a Texas corporation licensed by the Texas Department of Insurance as a Health Maintenance Organization.

- **Homebound Member**. A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services**. Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.

- **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

- **Hospital**. An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility**. The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical Emergency**. The recent onset of a medical condition of severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

  1. placing the patient's health in serious jeopardy,

  2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, loss of consciousness, injuries involving treatment to the mouth and teeth, and conditions that have progressed from a non-emergent situation initially to that of an emergent nature over a period of time, of a few days to as long as a week.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the **Covered Benefits** section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.
- **Member**. A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

- **Mental Health Treatment Facility:** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medical services that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Open Enrollment Period**. A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month, except that if the

month is February, the period shall last through March 2.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating**. A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician**. A duly licensed **Member** of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or **Certificate**.
- **Premium**. The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician**. A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider**. A **Physician, Health Professional, Hospital, Skilled Nursing Facility,** home health agency or other recognized entity or person licensed to provide **Hospital**, or **Medical Services** to **Members**.

- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Referral**. Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Respite Care**. Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.
- **Serious Mental Illness**: means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- **Service Area**. The geographic area, established by **HMO** and approved by the appropriate regulatory authority.
- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **Skilled Nursing Facility**. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.
- **Specialist**. A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber**. A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the **Premiums** section of the **Group Agreement**.
- **Totally Disabled or Total Disability**. A **Member** shall be considered Totally Disabled if:
  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Nos. 02-1845 and 03-83

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IN THE

Supreme Court of the United States

No. 02-1845

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

No. 03-83

CIGNA HEALTHCARE OF TEXAS, INC. and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI OF AETNA HEALTH, INC. AND CIGNA HEALTHCARE OF TEXAS, INC.

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QUESTION PRESENTED

Finding support in *Pegram v. Herdrich*, 530 U.S. 211 (2000), did the Fifth Circuit correctly hold that a state-law tort claim arising out of an HMO's mixed coverage and treatment decision is not completely preempted by section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B))?

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Respondents Juan Davila and Ruby Calad file this consolidated response in opposition to the petitions for writ of certiorari filed by their respective health-maintenance organizations, Aetna Health Inc. (No. 02-1845), and CIGNA HealthCare of Texas, Inc. (No. 03-83).

STATEMENT OF JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1). But whether the district court had jurisdiction under 28 U.S.C. § 1331—something the petitioners proffer as fact (Aetna, CIGNA Pet.'s at 1)—was actually decided in the negative by the Fifth Circuit. As a result, the assertion of these two HMOs that the district court "had jurisdiction" under both 28 U.S.C. § 1331 and the "complete preemption effected by 29 U.S.C. § 1132" is a characterization with which the appellate court disagreed (and which is the core issue here)—hence the judgment directing a remand to state court.

INTRODUCTION

Reversing the district courts' separately reached conclusions that they had jurisdiction over Davila's and Calad's state-law tort claims under ERISA § 502(a)'s complete-preemption doctrine, the Fifth Circuit held that those claims neither duplicated nor fell within the scope of a section 502(a)(1)(B) claim. According to the appellate court, Davila's and Calad's motions to remand their respective cases should have been granted, and the district-court judgments were therefore reversed.[1]

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1. If this Court either denies the petitions or affirms the Fifth Circuit on the merits, the Texas state courts will (undoubtedly) then be called upon to decide whether Davila's and Calad's claims

(Cont'd)

Drawing principally from an analysis of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)—an analysis further informed by *Pegram v. Herdrich*, 530 U.S. 211 (2000)—the Fifth Circuit concluded that Davila's and Calad's tort claims against the HMOs for the latter's mixed eligibility and treatment decisions differed substantively from the essentially contract-based benefit claims for which ERISA § 502(a)(1)(B) provides the exclusive remedy. (Aetna App. at 16a – 20a.)

That is, a state-law tort claim that an HMO's mixed eligibility and treatment decision caused personal injury to an HMO member is so unlike an ERISA § 502(a)(1)(B) claim to "recover benefits" due under an ERISA plan that the field preemption Congress intended with ERISA simply does not come into play.

(Cont'd)

are nonetheless to be dismissed due to ERISA § 514 conflict preemption, a purely defensive matter not conferring removal jurisdiction. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 23-27 (1983). Because section 502(a) complete preemption is very different from section 514's "relates to" preemption, the most efficient course seems to be for the Court to grant the petition in *Roark v. Humana, Inc.*, No. 02-1826 (pet. docketed June 17, 2003), a case dealing squarely with the broader question of whether ERISA § 514 preempts a state medical-negligence claim. (The Fifth Circuit consolidated *Roark*, *Davila*, and *Calad* for argument, and the opinion below resolved all three cases.) Aetna has asked for just the opposite approach: that the *Roark* petition be held until its petition here has been ruled on. (Brief for Respondent Aetna Health Inc., filed in *Roark*, No. 02-1826.) The undersigned, as counsel for Roark, will be filing a reply opposing that suggestion as having it backward, from the standpoint of both efficiency and logic.

Despite Aetna's and CIGNA's dramatic pronouncements,[2] this holding is not a radical departure from this Court's precedent; it does not conflict with controlling Supreme Court authority; and it does not conflict with the views of any other circuit on this precise issue.[3] Indeed, the decision below independently tracks that of the Second Circuit in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 01-9248 (U.S. July 11, 2003); and most recently, the Eleventh Circuit has joined in recognizing that the concept of HMOs' "mixed" decision-making, rightly considered in light of *Pegram*, yields a much more accurate understanding of what section 502(a)(1)(B) really means. *Land v. CIGNA Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003).

In short, this Court need not grant Aetna's or CIGNA's petitions, for any purported conflict is illusory. Respondents do agree that the whole area of ERISA preemption is of great importance, particularly in its recurring forms, but contend that if the Court were to grant the petition instead in *Roark v. Humana*, No. 02-1826, and reverse the Fifth Circuit's holding in that case, a broader—and thus more likely final—word on section 514 "relates to" preemption would put to rest much of the current uncertainty, as it would necessarily resolve the narrower section 502(a)(1)(B) issue here involved.

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2. *E.g.*, Aetna claims that the Fifth Circuit has "categorically exempt[ed] state tort actions from complete preemption" (Aetna Pet. at 9), when in fact nothing of the sort has occurred.

3. The circuit-court cases cited by petitioners may be superficially at odds with the Fifth Circuit's holding, but they are readily distinguishable, as Respondents will show.

STATEMENT OF THE CASE

If the Court grants the petitions and receives briefing on the merits, the respondents will provide a more detailed factual recitation. For purposes of opposing the petitions and providing the necessary background for the Court to consider the Fifth Circuit's holding, the respondents proffer the following:

Juan Davila

Davila's employer, Monitronics, set up an ERISA employee-benefit plan, which in turn contracted with Aetna for its employees' health coverage. (Aetna App. at 67a, 85a.) Aetna—not Davila's employer or that employer's ERISA plan—created a drug formulary that included Vioxx. (Aetna App. at 67a.) Though Davila's treating physician prescribed Vioxx to alleviate this post-polio diabetic's arthritis pain, Aetna required Davila's treating physician to first place him in a "step program" under which Davila had to try two (cheaper) medications and either suffer an adverse result or show no improvement before Aetna would pay for a Vioxx prescription. (Aetna App. at 67a – 68a.)

Davila in fact suffered an adverse reaction to naprosyn, one of the cheaper drugs that has been shown to have a higher incidence of gastrointestinal bleeding and ulceration than Vioxx: after being rushed to the emergency room, doctors discovered that Davila suffered from bleeding ulcers that resulted in a near heart attack. The emergency-room doctors told Davila that he was only hours away from dying of internal bleeding, and he can no longer take any pain

medication that has to be absorbed through the stomach. (Aetna App. at 68a.)

By referring often to an "ERISA plan" and to Aetna's "Certificate of Coverage," Aetna's statement of the case attempts to cast this situation as one involving nothing more than a coverage dispute rather than, as the Fifth Circuit concluded, one that plainly had components of both coverage (eligibility) *and* treatment decisions.[4]

Ruby Calad

As did Aetna, Calad's HMO (CIGNA) made decisions with both coverage and treatment components when its discharge nurse declined to approve the request of Calad's treating surgeon that she be allowed to stay in the hospital for more than one day following a hysterectomy with rectal, bladder, and vaginal repair. (Aetna App. at 3a.) Calad was sent home, where she suffered complications that led to her emergency readmission to the hospital a few days later. (*Id.*)

And as it did with Aetna, the Fifth Circuit concluded that CIGNA's "mixed" decision featured "the type of 'when and how' medical necessity questions . . . that fall within *Pegram*'s rule." (Aetna App. at 14a.)

Both Davila and Calad sued under the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE §§ 88.001 – 88.003 (Aetna App. at 56a – 63a), a statute that creates a cause of action against HMOs (among others) for damages

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4. "It seems beyond dispute that . . . Davila's claims involve such mixed decisions. . . . Aetna agrees its plan includes a range of arthritis drugs, so we are not presented with simple yes-or-no coverage questions." (Aetna App. at 13a – 14a.)

caused by a failure to use ordinary care in making health-care treatment decisions.[5]

REASONS FOR DENYING THE PETITIONS

The opinion below is consistent with this Court's precedent.

Careful examination of this Court's prior cases dealing with ERISA § 502(a) reveals that the Fifth Circuit correctly recognized that a contract–tort distinction is both appropriate and in keeping with ERISA's purposes. As this Court has held, it is ERISA's "repeatedly emphasized purpose to protect contractually defined benefits." *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985); *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (reiterating ERISA's focus on contractually defined benefits).

In contrast (and as the Second Circuit noted in *Cicio*, 321 F.3d at 99-100), state medical-malpractice law, "even if implicated by the execution of a benefits decision," *id.*, involves duties that exist and are defined independent of ERISA plans and thus cannot be counted among the "rights and expectations brought into being by [ERISA]," *Ingersoll-Rand*, 498 U.S. at 137, rights that section 502(a) was designed to protect.

---

5. "Health care treatment decision" is defined in the THCLA as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." TEX. CIV. PRAC. & REM. CODE § 88.001(5) (Aetna App. at 56a). "Ordinary care," as applied to an HMO, means "that degree of care that . . . [an HMO] . . . of ordinary prudence would use under the same or similar circumstances." Section 88.001(10) (Aetna App. at 57a).

Petitioners' touchstone for the contrary proposition is *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), a case that involved a claim for improper processing of disability benefits. Principally a decision that ERISA § 514 preempts any contract and state-law bad-faith tort claims, and, secondarily, that ERISA § 502(a) provides the exclusive vehicle for redressing all such claims, *Pilot Life* does not resolve, or even address, the present issue: what are the boundaries of the term "benefits" that appears in section 502(a)(1)(B), in the context of medical treatment? Or, as the question might be framed here, are "benefits" limited to an obligation to pay for contractually defined services, or do "benefits" include an externally mandated medical standard of ordinary care under state law, which Congress somehow intended for ERISA to usurp?

In reading "benefits" to subsume only the former, and in keeping with this Court's precedents, the Second Circuit aptly summarized the distinction in a passage worth repeating in its entirety:

> Even if, absent a benefits contract, no medical care would in fact have been furnished, so that the medical judgment in one sense is a "benefit" and a direct consequence of the exercise of a contractual right, the state law obligation to provide care of a given level of quality when providing care is nonetheless distinct from the contract. (*Cicio*, 321 F.3d at 100, n.11.)

That conclusion is consistent not only with *Pilot Life* but also with *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), in which the Court again held that section 514

preempted state-law claims arising out of the denial of disability benefits, including a related claim of retaliatory discharge, and that the remedies found in section 502(a) create removal jurisdiction.[6]

The distinction between contract-based duties that section 502(a) was designed to protect and those here involved under Texas health-care law is not undercut, despite Aetna's argument, by *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (discussed at pp. 14-16 of Aetna's petition). There, the plaintiff sued in state court under a wrongful-discharge theory that his employer fired him to avoid having to pay pension benefits. Not surprisingly, this Court found that claim preempted under section 514, largely because it could not exist without reference to an ERISA plan (". . . this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself," *id.* at 140 (emphasis in original)).

Only *after* finding section 514 preemption did the Court turn to its secondary holding: that even without section 514 preemption, the state-law claim would be preempted because it conflicted directly with an ERISA cause of action, set out in section 510 and enforceable through section 502(a).[7]

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6. The fact that, in both *Pilot Life* and *Metropolitan Life*, the Court began its analysis with section 514 and only afterward moved on to a section 502(a) discussion further militates in favor of considering the petition in *Roark v. Humana, Inc.*, a section 514 decision, before considering Aetna's and CIGNA's petitions. (The same analytical pattern appears in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).)

7. ERISA § 510 expressly makes it unlawful, among other things, to fire someone in order to interfere with a right to which he might be entitled under an ERISA plan. 29 U.S.C. § 1140.

In other words, because the Texas claim *duplicated* one that ERISA already provided (even though the remedies differed), the state claim had to yield to ERISA's preemptive force. *See also Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (finding preempted a Washington state statute governing distribution of life-insurance proceeds to former spouses, where that statute directly conflicted with an ERISA provision on the same subject; "unlike generally applicable laws regulating '*areas where ERISA has nothing to say*,' . . . which we have upheld notwithstanding their incidental effect on ERISA plans, . . . this statute governs the payment of benefits, a central matter of plan administration." [*Id.* at 147; emphasis added]). Plainly, ERISA has "nothing to say" about medical standards of ordinary care, a topic left entirely to the states.

Although the petitioners scoff at the Fifth Circuit's holding that only a claim duplicating an existing one under ERISA is properly preempted under section 502(a), in fact that holding finds support as recently as last year, when the Court decided *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). In that case, the Court correctly noted that since *Pilot Life*, it has found only one other state law (the one involved in *Ingersoll-Rand*) to "conflict" with section 502(a) "in providing a prohibited alternative remedy." *Id.* at 379. As the Court explained *Ingersoll-Rand*,

> . . . while state law duplicated the elements of a claim available under ERISA [*i.e.*, a section 510 claim], it converted the remedy from an equitable one under [section 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal).

Id.

Nothing about the Fifth Circuit's decision below conflicts with this or any other binding authority, for the simple reason that *no* case from this Court has confronted, in the section 502(a)(1)(B) context, whether a state-law claim rooted in a duty beyond that to properly process a claim for ERISA benefits "falls within the scope" of section 502(a). *See Metropolitan Life*, 481 U.S. at 64. Aetna's statement, at page 12 of its petition, that "any suit *touching the same subject matter* becomes a Section 502(a) claim" (emphasis added) thus incorrectly conflates section 514's "relates to" provision with the much narrower question of whether a state-law medical-malpractice claim is one that falls under section 502(a)(1)(B) in the first instance.

And to further understand the correctness of the Fifth Circuit's decision, the state-law claims found to be subsumed within section 502(a) in both *Pilot Life* and *Metropolitan Life* must be distinguished from what a state may properly regulate wholly independently of ERISA. Though understandably (but somewhat disingenuously) neither Aetna nor CIGNA mentions it, this Court has in recent years consistently recognized that the field of health care is a "subject of traditional state regulation, [and] there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Inc. Co.*, 514 U.S. 645, 654-55 (1995).[8]

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8. *See also California Div. Of Labor Standards Enforcement, N.A., Inc. v. Dillingham Constr.*, 519 U.S. 316, 330 (1997) (there must be an "indication in ERISA . . . [or] its legislative history of [an] intent on the part of Congress to preempt a traditionally

(Cont'd)

Though the Court's retrenchment from the virtually limitless view of ERISA preemption that inhered when it decided *Pilot Life* and *Metropolitan Life* came about in the context of section 514, the analysis is of critical importance to a proper view of what kinds of disputes about "benefits" fall within the scope of section 502(a)(1)(B). That view is significantly circumscribed by *Pegram*, even though *Pegram* was not a preemption case, because the Court has now drawn a clear distinction between purely administrative decisions (such as whether a particular contract *covers* a particular condition or treatment), and the far more common ones that involve both a coverage and a treatment decision.

In *Pegram*, Lori Herdrich complained that her health-care provider, a group of doctors who could earn bonuses through their physician-owned HMO by minimizing the amount of care and by referring patients only to facilities controlled by the group, breached its fiduciary duty under ERISA by having such an arrangement. The Court disagreed, holding that a physician's delaying needed treatment to save money for the HMO and to increase the physician's compensation did not breach ERISA's fiduciary-duty provisions.

(Cont'd)

state-regulated substantive law"; "if ERISA were concerned with any state action—*such as medical-care quality standards. . .*—that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we would scarcely see the end of ERISA's pre-emptive reach" [emphasis added]); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) ("[H]istoric police powers of the State [which the Court assumes ERISA was not meant to supersede] include the regulation of matters of health and safety.").

Pegram is a logical extension of the *Travelers–De Buono–Dillingham* trilogy, which established that ERISA's preemptive reach was not so broad as earlier thought. According to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. *See* 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan").

530 U.S. at 236.

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 237. (And, manifestly, nothing in ERISA suggests that Congress intended to preempt state-law regulation of medical decision-making, even in the guise of "medical necessity.")

Importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about *how* to go about diagnosing and *treating* a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

530 U.S. at 228 (emphasis added).

The Court then concluded that Herdrich's complaint raised "just such mixed eligibility and treatment decisions." *Id.* at 229. Juan Davila's and Ruby Calad's claims do, too: instead of allowing their doctors to determine how they should be treated, Aetna and CIGNA took upon themselves the role of deciding the "appropriate medical response," even though, respectively, Vioxx was on the Aetna formulary, and CIGNA covered hospitalizations for surgeries such as hysterectomies.

In the next section of the *Pegram*, the Court opined that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." 530 U.S. at 231.

A finding of no fiduciary status with regard to medical-necessity decisions is tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions; *Pegram*'s holding and reasoning, especially

when coupled with the Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result. And that is exactly what the Fifth Circuit concluded:

> Any doubts we might have [about holding that § 502(a)(1)(B) preempts only duplicative causes of action] are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice. *See Pegram*, 530 U.S. at 236-37. We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B).

Aetna App. at 20a.

In short, the Fifth Circuit, far from ignoring or flouting this Court's precedent, has issued an opinion that flows logically from *Pilot Life* up to the present.

There is no circuit split—indeed, post-*Pegram *decisions from two other circuits considering this issue are in accord with the Fifth Circuit.

Aetna and CIGNA strive to posit a circuit split on whether state medical-malpractice claims against an HMO are completely preempted by section 502(a). But the cases on which they rely are distinguishable either because they did not involve a state medical-malpractice claim (or really

did involve purely administrative decisions), or because they pre-date *Pegram* (or fail to consider its import).

But before distinguishing the petitioners' cases, Davila and Calad would note that the Fifth Circuit has now been joined in its essential holding by the only two other circuits to confront this precise issue after *Pegram*.

In *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 01-9248 (U.S. July 11, 2003), the magistrate judge had found that section 502(a) completely preempted all the plaintiff's state-law claims, including one for medical malpractice. (The district court adopted the magistrate's report in its entirety.) The Second Circuit affirmed that conclusion and consequent dismissal of two of the claims, but reversed as to the medical-malpractice claim.

Carmine Cicio was covered under an HMO plan that limited the HMO to providing only "medically necessary" services. The plan further provided that the HMO was not obligated to cover any treatment that, in the HMO medical director's judgment, was experimental or not generally recognized for the condition in question.

After Cicio's cancer did not respond to initial therapies, his treating oncologist requested that the HMO approve treatment with high-dose chemotherapy coupled with a double stem-cell transplant. The HMO decreed that such transplants were experimental and denied the request. The oncologist responded with an explanation of this "well-established method of treatment" (321 F.3d at 88), together with citations to pertinent medical literature. The HMO again

refused the request to approve a double transplant; less than two months later, Mr. Cicio died.

His widow sued the HMO in state court, alleging medical malpractice and other state-law claims. After the HMO removed the case, the district court dismissed the complaint based on ERISA § 502(a) preemption, concluding that Mrs. Cicio sought a remedy that would involve enforcing the terms of an employee-benefit plan.

The Second Circuit reversed in part. It first held that Mrs. Cicio's claim of "untimeliness," based on a New York statute that imposed a shorter period than do certain ERISA regulations for handling an appeal of a denial of care, was completely preempted as "an alternative mechanism . . . for enforcing the rights protected by ERISA." *Id.* at 95 (internal citations omitted). The Second Circuit also held that a state-law claim of misrepresentation was similarly "within the scope of § 502(a)" *id.* at 94 (citing *Metropolitan Life v. Taylor*, 481 U.S. at 66), because it sought to "vindicate rights accruing under the plan." *Id.* at 96. As a result, the HMO's removal was proper, and the district court had jurisdiction (unlike in Davila's and Calad's cases, but like Roark's).

Because section 502(a) created jurisdiction over those aspects of Cicio's claims, the Second Circuit's consideration of the medical-malpractice claim went straight to conflict preemption under section 514: "The question [is] whether a state law medical malpractice claim brought with respect to a medical decision made in the course of prospective utilization review by a managed care organization or health insurer is preempted under ERISA § 514, and therefore beyond the reach of state tort law. . . ." *Id.* at 98.

Though recognizing that earlier cases from other circuits had been decided oppositely, the Second Circuit concluded that, based on *Pegram*, the mere fact that a particular health-care decision contains an administrative (eligibility) component "no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component." *Id.* at 103.[9]

In addition to its lengthy discussion of *Pegram*, several features of *Cicio* are noteworthy here. First, the Second Circuit pointed out that ERISA's "repeatedly emphasized purpose [is] to protect *contractually* defined benefits." *Id.* at 99 (quoting *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985); emphasis in *Cicio*). By contrast, state medical-malpractice law "involves the application of duties of conduct that are defined independent of ERISA plans." *Id.*

Second, the court noted its "skepticism" of reasoning that would draw from a statute meant to protect employees "the elimination of protective standards of professional conduct." *Id.* at 103-04. The court thus saw

> no reason . . . to bar as preempted state law malpractice actions that rest on the application of

9. The Ninth Circuit might be aligning itself with the Second Circuit, although the exact question has not arisen. *See Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847 (9th Cir. 2002) (citing both *Rush Prudential* and *Pegram* and holding that Federal Employees Health Benefits Act (FEHBA), which contains preemption language similar to ERISA, did not preempt pure medical-malpractice claim brought by a FEHBA participant against her plan; claim was not a preempted denial-of-benefits claim). *See also Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842 (Fla. 2003) (citing *Cicio* approvingly in the course of holding that ERISA § 514 did not preempt plaintiff's vicarious-liability claim against HMO).

> standards for medical decision-making—which are established by states *independent of and prior to health benefits contracts*—to "a patient's constellation of symptoms."

Id. at 104, quoting *Pegram*, 530 U.S. at 228 (emphasis added).

Though *Cicio*'s analysis proceeded under section 514, it necessarily means that the medical-malpractice claim was not preempted under section 502(a), since the latter is simply a subset of the former. In other words, as the Fifth Circuit put it in the decision below, "any claim that falls within § 502(a) necessarily falls within § 514. . . ." (Aetna App. at 15a, n.11.)

In a case most procedurally akin to Davila's and Calad's, last month the Eleventh Circuit conducted a section 502(a)(1)(B) analysis of state medical-malpractice claims, found them not completely preempted, and directed a remand to state court. *Land v. CIGNA Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003).

There, an HMO nurse overrode two physicians' collective decision that Robbie Land should be hospitalized in order to receive intravenous antibiotics for a serious infection. After being treated on an out-patient basis for several days, Land's condition worsened considerably, and he ultimately had to have the infected finger amputated. Land sued CIGNA in state court for medical negligence, and CIGNA removed to federal court based on section 502(a).

In its analysis, the Eleventh Circuit recognized that the first step was to determine whether Land's claims fell within the scope of one of the three categories of section 502(a)(1)(B). Easily ruling out a construction of the claims as involving seeking "to clarify his rights to future benefits" or "to enforce his rights under the terms of [his health care] plan," the court was left to consider whether the claims were ones "to recover benefits." 2003 WL 21751247 at *3. In that regard, the court relied heavily on *Pegram*, concluding after extensive discussion that the CIGNA nurse had made a "mixed" eligibility and treatment decision because rather than being a "simple yes-or-no eligibility determination about whether CIGNA would cover treatment for cellulitis," the eligibility decision was instead "intertwined with the approval nurse's *medical* decision that inpatient treatment of Land's infection was unnecessary." *Id.* at *5 (emphasis added).

Having reached that stage in the analysis, the *Land* court then turned to the final inquiry: Are mixed-decision claims ones "to recover benefits" under section 502(a)(1)(B) and therefore completely preempted? Once again, the Eleventh Circuit found *Pegram*'s reasoning persuasive.

Citing that portion of *Pegram* in which this Court expressed strong doubt that Congress meant to federalize and preempt state malpractice claims by transmuting them into section 502(a)(2) fiduciary claims or to "apply[ ] an ERISA standard of reasonable medical skill," 530 U.S. at 236, the Eleventh Circuit—in a conclusion virtually identical to that reached by the Fifth Circuit here—found that

> . . . it makes little sense to believe that Congress did not intend to federalize malpractice claims

> under section 502(a)(2), but intended to do so under section 502(a)(1)(B).

2003 WL 21751247 at *6.

The *Land* court also noted its own precedent that viewed section 502(a)(1)(B) claims as "essentially . . . contract claims." *Id.* (citing cases). And because Land neither alleged that he was denied medical benefits nor sought reimbursement of medical expenses, but instead claimed that his personal injuries resulted from CIGNA's "failure to diagnose his condition correctly and authorize the proper medical treatment," his claims were "tort claims based upon the duty of care rather than contract claims based solely upon a denial of benefits." *Id.* For that reason, the court found CIGNA's reliance on *Pilot Life* to be "misplaced": "As we do not believe that Land's malpractice action is based solely upon the improper processing of a claim, *Pilot Life Insurance Co.* does not foreclose our holding in this case. " *Id.*, n.5.

Cicio and *Land* deal directly with the controlling issue here. The cases cited by Aetna and CIGNA do not, and therefore no circuit split exists.

The lead-off "contrary" case in both petitions is *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), which Aetna characterizes as "reaffirm[ing] that plaintiffs may not circumvent Section 502(a)'s exclusivity by bringing state-law claims relating to *benefits administration*—however cleverly those claims might be characterized." (Aetna Pet. at 20 [emphasis added].) That statement of the law is unassailable—but neither the legal principle nor the facts of *Marks* have much to do with Davila's and Calad's claims.

There, it was the sheer factual deficiencies in the plaintiff's claims against the decedent's PPO's subcontractor as much as anything that resulted in a holding of section 502(a) complete preemption. The decedent (who, following his discharge from in-patient psychiatric care, murdered his wife and child and then killed himself) was a member of a preferred-provider organization ("PPO"), not an HMO. That PPO subcontracted with another company to perform utilization-review and other administrative services.

It was undisputed that the subcontractor, Mainstay, had no input into or involvement whatsoever in the decedent's medical treatment; the decedent's treating physicians never spoke with Mainstay's employee (the named defendant, Watters); the decision to discharge the decedent from in-patient care was made *solely* by the physicians, with no pressure from or discussion with Mainstay; and Mainstay's employee was told by the hospital of "medical treatment decisions and diagnoses only after the doctors had *already* made them." *Id.* at 326 (emphasis in original).

Not surprisingly, on these facts the Fourth Circuit rejected the plaintiff's attempt to argue that Mainstay somehow made a "mixed" decision that incorporated some treatment component (an argument made to try to bring the claims within *Pegram*'s reasoning, since purely administrative decisions are of course completely preempted). As the *Marks* court held, a plaintiff

> cannot transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making *unsubstantiated and incorrect* statements that an independent

> utilization review agent was responsible for medical decisions.

Id. at 326 (emphasis added).

As a result of these clear factual inadequacies, the *Marks* court never had to reach the issue of whether, if Mainstay's conduct *had* included a treatment component, the "mixed" nature of the decision-making would, consistent with *Pegram*'s implications, take the case out of section 502(a)'s preemptive ambit.

Just as *Marks* thus sheds little light on the issue on which the Fifth, Second, and Eleventh Circuits have now shown a united front, neither do Aetna's and CIGNA's other cases. Without going into a detailed discussion of each of them, all but one of the post-*Pegram* cases did not even assert claims involving state health-care standards or medical malpractice—a particularly immaterial category since the states are empowered to regulate such matters, thus making *Pegram* (and the trilogy) a critical piece of the preemption puzzle. Petitioners' post-*Pegram* cases not involving a health-care-related claim are these:

- *Fink v. Dakotacare*, 324 F.3d 685 (8th Cir. 2003) (state-law claims for breach of contract, unfair trade practices, and unspecified torts arising out of insurer's denying claim for COBRA continuation benefits under former employer's group health plan held completely preempted);

- *Conover v. Aetna U.S. Healthcare, Inc.*, 320 F.3d 1076 (10th Cir. 2003) (bad-faith claim arising out of administration of disability benefits completely preempted);

- *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002) (per curiam) (claims for breach of contract, tortious breach of statute, and bad faith preempted under section 514);

- *Hotz v. Blue Cross and Blue Shield of Massachusetts, Inc.*, 292 F.3d 57 (1st Cir. 2002) (state statutory claim permitting damages and attorney's fees for unfair or deceptive acts or practices in conduct of trade or commerce completely preempted).[10]

The petitioners' only other case that post-dates *Pegram* is *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), in which the Third Circuit held, unremarkably, that a claim of HMO liability for delay in approving a referral to an out-of-network provider involved a purely administrative decision that was thus completely preempted.

A number of Aetna's remaining cases[11] pre-date *Pegram* and accordingly are of even more questionable utility. (Three

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10. Aetna's discussion of *Hotz* misleadingly intimates that the plaintiff's "attack on a pre-approval decision" that "allegedly caused the plaintiff's cancer to worsen" (Aetna Pet. at 22) had something to do with a state malpractice or health-care-related claim, when no such claim was advanced. Thus, Aetna's applauding the Eighth Circuit for "not [being] distracted . . . by *Pegram*'s elaboration [of eligibility, treatment, and mixed decisions]" is false flattery: nothing about the plaintiff's unfair-trade-practices claim would have logically brought *Pegram* into the discussion.

11. *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam) (case did not even discuss *Travelers* trilogy); *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999) (no discussion of trilogy); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997); *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir. 1998).

of them even pre-date the *Travelers* trilogy, putting them roughly in the Pleistocene era of ERISA-preemption law; those three are *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir. 1996); and *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995).)

In sum, the petitioners' claim of a "firmly entrenched" circuit split (Aetna Pet. at 28) is simply wrong. Three circuits—and three circuits only—have dealt, after *Pegram*, with whether an HMO's mixed eligibility and treatment decision takes a state medical-negligence claim out of ERISA's preemptive scope and leaves it to state law where health-care matters have traditionally been regulated. And those three circuits, the Fifth, Second, and Eleventh, have all agreed that *Pegram*'s teaching, viewed through the prism of *Pilot Life* and its progeny, warrants a conclusion that Congress did not intend to preempt state malpractice law and that a section 502(a)(1)(B) contract-based claim to "recover benefits" cannot be stretched to cover a tort claim of medical malpractice.

CONCLUSION

Because the decision below does not run afoul of this Court's precedent, and because no circuit split exists on the issue of section 502(a)(1)(B) complete preemption, the petitions should be denied. The appellate court correctly ruled that the district court lacked jurisdiction under 28 U.S.C. § 1331, and further review is therefore not warranted.

In the alternative, the petitions should be held pending the Court's consideration of the petition in *Roark v. Humana, Inc.*, No. 02-1826, for that case truly does involve a circuit split: though the Fifth Circuit in *Roark* (reluctantly) held that the plaintiff's medical-negligence claim under the Texas Health Care Liability Act was conflict preempted under ERISA § 514, the Second Circuit in *Cicio* held precisely the opposite in a case involving a New York medical-negligence claim. Because resolution of the broader section 514 "relates to" issue would of necessity resolve any section 502(a)(1)(B) complete-preemption issue as well, *Roark* would seem the case of greater importance to ERISA-preemption jurisprudence.

Respectfully submitted,

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Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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REPLY BRIEF FOR PETITIONER

The Fifth Circuit's decision in this case creates a categorical exemption from ERISA's exclusive remedial scheme for any state cause of action sounding in tort. That holding is contrary to all of this Court's decisions considering "complete preemption" under ERISA § 502(a), and to the majority of decisions of the courts of appeals, most of which adhere to this Court's holding that tort claims are preempted as supplemental remedies rejected by Congress. Respondent Davila defends the judgment below by attempting to invent further subcategories of medical torts and health-benefit decisions that enjoy such categorical immunity from preemption. Although a minority of the courts of appeals has accepted these purported distinctions, they are without support in this Court's cases. Because of the significance of complete preemption for federal jurisdiction as well as uniform national benefit-plan administration, plenary review by this Court is sorely needed to resolve the deepening divide over Section 502(a)'s preemptive effect.

I. This Court's Review Is Warranted To Resolve The Widening Conflict Among The Lower Courts Over The Question Of Complete Preemption

This Court has made clear, and most lower courts have dutifully accepted, that a State may not supplement the remedies available in a challenge to a benefits-administration decision. *E.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-54 (1987); Pet. 19-25. The decision below deviates from that rule by creating an unsupported exception for any state-law claim that seeks a remedy in tort. Pet. App. 16a-17a. That broad holding, as the petition demonstrates, is altogether at odds with *all* of this Court's complete-preemption cases and with the decisions of a majority of other circuits. Pet. 10-28.

A. Davila Proffers Only An Untenable Distinction Between The Decision Below And Cases Following The Majority Rule That ERISA Preempts Supplemental State Remedies

Davila seeks to explain away the divide between the decision below and the numerous holdings (by this Court and others) with which that decision conflicts by asserting that a different preemption rule applies to tort claims related to *health* benefits and asserted under (variously) state negligence law, state malpractice law, or a state HMO-regulation statute.[1] Opp. Br. 14-15. Such a distinction is untenable as a matter of law: nothing in ERISA or this Court's cases countenances carving an exception from ERISA's nationally uniform framework for plan-administration decisions that involve medical benefits. *Cf.* ERISA § 3(1), 29 U.S.C. § 1002(1) (definition of "employee welfare benefit plan" does not differentiate among health, disability, vacation, or other benefits). Davila's assertion that the cases with which the decision below conflicts are off point because they do not involve health benefits and "mixed eligibility and treatment decisions" simply assumes that these distinctions have some legal significance in the preemption context. That assumption is faulty.

1. Davila's proposed distinction is based on a misreading of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), a case whose context-specific holding did not turn on the preemption of state law at all. *E.g.*, *Cicio v. Doe*, 321 F.3d 83, 109 n.4 (2d Cir. 2003) (Calabresi, J., dissenting)

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[1] *See Land v. CIGNA Healthcare of Fla.*, No. 02-15549, 2003 WL 21751247, at *1 (11th Cir. July 30, 2003) (negligence), *cited in* Opp. Br. at 18-20; *Cicio v. Doe*, 321 F.3d 83, 90 (2d Cir. 2003) (malpractice), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003), *cited in* Opp. Br. at 15-18; Pet. App. 5a (HMO-regulation statute).

("*Pegram*, of course, was not a preemption decision."), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003). In *Pegram*, this Court considered whether a patient stated a claim for breach of fiduciary duty under ERISA by alleging that her *physician-owned* HMO had considered cost-containment factors in prescribing her course of treatment. *E.g.*, 530 U.S. at 220, 222, 227-28. Because in that case, the HMO owners who made coverage determinations were also the treating physicians, the same person necessarily made the "eligibility" and "treatment" decisions. *Id.* at 229-30. The Court rejected the notion that ERISA provides a cause of action for breach of fiduciary duty against *physicians*, or HMOs that employ them directly. *Id.* at 235-37. "[M]ixed eligibility decisions *by HMO physicians*," the Court held, are not fiduciary decisions within the meaning of ERISA § 409, 29 U.S.C. § 1109. *Pegram*, 530 U.S. at 237 (emphasis added).

Davila's error is to assume that *all* coverage decisions relating to health benefits are always and everywhere "mixed eligibility and treatment decisions." Because most coverage decisions relating to health benefits have some medical ingredient—no payment ordinarily is available unless a particular treatment is medically "necessary" under criteria established by the plan—Davila concludes that an HMO necessarily engages in "treatment" that is "mixed" with its "eligibility" judgment whenever it decides not to pay for a procedure recommended by the treating physician. But as the Solicitor General recently noted before this Court, while "[s]ome statements in *Pegram*, if read in isolation, might suggest that such 'mixed decisions' . . . are never fiduciary acts under ERISA, . . . [t]he better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians." Brief for the United States as Amicus Curiae at 8, *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (Nov. 7, 2001). Indeed, any other reading of *Pegram* would run contrary to "the background provisions of ERISA itself and

longstanding Labor Department regulations." *Id.* at 9; *see also Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting). In Davila's view, by contrast, it would appear that a plan administrator's health coverage decisions or policies are *never* fiduciary in nature, since they are likely to include *some* "medical" component.

There is a world of difference between a treating doctor's cost-based decision not to *order* an ultrasound at a nearby hospital (*Pegram*, 530 U.S. at 215), and a plan administrator's decision not to *pay for* a procedure that a physician recommends or performs. In this case, for example, Aetna did not purport to decide what drug would be the "appropriate medical response" to Davila's arthritis (Opp. Br. 13 (quoting *Pegram*, 530 U.S. at 228)); rather, it merely made the coverage decision that, absent contraindication or participation in the "step program," the Monitronics plan did not authorize *payment* for Vioxx. *See* Pet. 3 & n.2. Davila cannot bridge that wide gap merely by asserting that Aetna's decision not to pay for a medication prescribed by a non-employee doctor should be re-labeled as medical "treatment."

Thus, Davila's assertion that the decision below cannot be said to conflict with any decision of the First, Third, Fourth, Eighth, Tenth, or any other circuit that does not involve "mixed eligibility and treatment decisions" is wholly spurious. Neither this case nor *any* of the cases discussed in the petition involved benefits administrators who also make decisions about medical *treatment*. Rather, *all* of the cases on both sides of the divide involved plan beneficiaries who sought to challenge decisions about plan administration—and in particular decisions not to pay for assertedly "necessary" treatments or procedures—through state-law causes of action. Most of these courts held that those state-law claims are completely preempted under *Pilot Life* and its progeny. Pet. 20-25. The Fifth Circuit in this case took the contrary view. It would be difficult to posit a starker circuit conflict.

2. Davila is also wrong to suggest that the *Pegram* Court somehow discovered for the first time that health benefits administration may turn on antecedent medical judgments about whether a treatment is necessary or appropriate under the circumstances. *See* Opp. Br. at 14-15, 23. Well before *Pegram*, the courts of appeals had uniformly recognized that a basic feature of health insurance in the HMO setting is that HMOs agree to reimburse only "medically necessary" services. *See, e.g.*, *Danca v. Private Health Care Sys.*, 185 F.3d 1, 5-6 & n.5 (1st Cir. 1999); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489 (7th Cir. 1996); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993). Indeed, *Pegram*'s discussion of this point drew on a leading decision from the Third Circuit, *see Pegram*, 530 U.S. at 227-28 (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995)), a court that continues to produce decisions at odds with the decision below. *See Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273-75 (3d Cir. 2001); Pet. 21-22.

In *Danca*, for example, the First Circuit specifically noted the "quasi-medical" character of a decision not to precertify treatment recommended by the beneficiary's treating physician. Nonetheless, the court held completely preempted a claim for tort damages attributed to that decision, because the challenged "conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan." 185 F.3d at 6. Unlike the Fifth Circuit in this case, the First Circuit has not found anything in *Pegram* that warrants revisiting that conclusion: it recently reaffirmed *Danca*. *See Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 60 (1st Cir. 2002). Davila does not so much as mention *Danca*, and he attempts to distinguish *Hotz* solely on the ground that (although it also arose from a failure to precertify health coverage) it involved a different "tort" from the ones he alleges (Opp. Br. at 23 n.10)—a distinction that

would appear irrelevant in light of the broad "tort-contract" divide that the Fifth Circuit adopted in the decision below.

In the end, Davila's *Pegram* arguments are not only legally insubstantial, but also completely inadequate to avoid certiorari. This Court made clear in *Pegram* itself that it was not passing on any preemption question, and thus nothing in *Pegram* can justify the Fifth Circuit's decision to depart from the consistent course of this Court's "complete preemption" decisions, which spans 15 years from *Pilot Life* to *Rush Prudential*. In each of the four such cases that received this Court's plenary consideration, *every* Justice who participated espoused a rule of law that is concededly at odds with the decision below. Even if Davila could plausibly argue that *Pegram* suggests the need to reconsider those decisions (and he cannot), the Fifth Circuit could not properly agree with him. *See Agostini v. Felton*, 521 U.S. 203, 237 (1997); *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989).

B. Recent Decisions Of The Ninth and Eleventh Circuits Have Widened The Divide And Heightened The Need For This Court's Review

The significant and entrenched division among the courts of appeals has widened even during the pendency of this petition: the Ninth and Eleventh Circuits recently joined the fray, taking opposite sides. The Ninth Circuit recognized that state-law claims seeking damages not available under ERISA § 502(a) are preempted when the challenged conduct is an ERISA plan administrator's decision whether to pay benefits under the terms of the plan. The Eleventh Circuit, by contrast, recently announced a *Pegram*-based preemption doctrine similar to the one adopted by the Fifth Circuit in this case. These decisions make even clearer that, until this Court resolves the issue, the division among the courts of appeals will continue to frustrate ERISA's goal of a uniform, nationwide regime of benefits administration.

1. In *Elliot v. Fortis Benefits Insurance Co.*, 337 F.3d 1138 (9th Cir. 2003), the Ninth Circuit held that *Pilot Life*'s core holding continues to govern claims against a plan administrator relating to the administration of benefits. Fortis terminated Elliot's disability benefits because her cancer resulted from a pre-existing condition and thus was excluded under the plan. *Id.* at 1141. Elliot sued in tort under a Montana unfair-claim-settlement statute that allowed recovery of punitive damages. *Id.* at 1147. The Ninth Circuit held the claim completely preempted by Section 502(a). *Id.*

Notably, *Elliot* took a position directly contrary to the decision below—and faithful to this Court's precedents—in holding that a state-law claim may be preempted as a supplemental remedy even if it does not *precisely duplicate* one of Section 502(a)'s rights of action. In the Ninth Circuit's view, an action that "seeks non-ERISA damages for what are essentially claim processing causes of action, *clearly* falls under the § 1132 preemption exemplified by *Pilot Life*." *Elliot*, 337 F.3d at 1147 (emphasis added). And the Ninth Circuit noted that this Court had recently reaffirmed that Section 502(a) preempts "'the sort of additional claim *or remedy* exemplified in *Pilot Life*.'" *Id.* (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 378, 380 (2002)) (emphasis added). The Montana statute sought to give just such an additional remedy; like the THCLA in this case, it "provides damages above and beyond those provided in ERISA, including punitive damages." *Id.*

Elliot, which Davila does not mention, is directly contrary to the decision below. The Fifth Circuit, misreading this Court's decision in *Rush Prudential*, held that precise duplication of a Section 502(a) cause of action is the *sine qua non* of complete preemption, and it even held that Davila's THCLA claim was not completely preempted *because* it sought tort damages not available under ERISA, rather than lost benefits recoverable under Section 502(a)(1)(B). Pet.

App. 17a, 20a. As the petition explains, that holding misunderstands *Rush Prudential* and is also at odds with this Court's complete-preemption cases. *See* Pet. 15-16 & n.5, 18. Davila seeks to defend the erroneous holding by pointing to a passage in *Rush Prudential*. *See* Opp. Br. 9. But the *Elliot* court specifically rejected the identical argument and explained why a requirement of precise duplication, like the Fifth Circuit's, is actually *contrary* to *Rush Prudential* and this Court's other cases. *See Elliot*, 337 F.3d at 1147.[2]

2. Also recently, in *Land v. CIGNA Healthcare of Florida*, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003), the Eleventh Circuit held that a plan administrator's pre-approval decision (denying the beneficiary inpatient treatment) was a "mixed decision of eligibility and treatment." *Id.* at *1, *6. The court stated (citing the decision below with approval) that actions challenging such decisions are not "claims 'to recover benefits' under section 502(a)(1)(B)," because claims under ERISA are contractual in nature, whereas Land's claims were "tort claims based upon the duty of care" and were "not challenging a denial of benefits." *Id.* at *6 & nn.5-6 (citing Pet. App. 16a-17a).[3]

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[2] The benefits decision at issue in *Elliot* also involved an aspect of medical judgment, just as was true in this case and many of the court of appeals cases on both sides of the divide. Indeed, the plan administrator relied on Elliot's own oncologist in determining that her cancer had metastasized from a pre-existing condition. *Elliot*, 337 F.3d at 1141. Yet because Fortis was not providing Elliot's medical care, but only *paying* for her care, its decision cannot be considered a mixed eligibility and treatment decision under the narrowly applicable *Pegram* framework, for the simple reason that Fortis provided no treatment (as is true of Aetna in this case).

[3] The Eleventh Circuit also cited *Pryzbowski* and *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), but as the petition discusses, those cases *reject* the notion that the medical consequences of a plan administrator's coverage decision place it in a new category free from preemption. Pet. 20-22.

These recent decisions confirm that the courts of appeals are profoundly divided on the question of complete preemption, and that this Court's intervention is urgently needed.

II. Because Preemption Under Section 502(a) Affects Federal Jurisdiction, That Issue Is Necessarily Antecedent To Any Other ERISA-Preemption Issue

In the vast majority of cases involving the distinct forms of ERISA preemption under Section 502(a) and Section 514, the Section 502(a) issue is logically considered first. Davila disputes this proposition in an attempt to bolster the certworthiness of a petition raising the Section 514 issue that his counsel of record has filed in a companion case (*Roark v. Humana, Inc.*, No. 02-1826) arising out of the same Fifth Circuit decision—a case in which this Court's jurisdiction would depend on the correctness of the jurisdictional analysis adopted by the Fifth Circuit in dealing with the "complete preemption" question in this case. Opp. Br. at 1 n.1, 8 n.6. Under those circumstances, the Constitution *requires* that the federal court adjudicate the jurisdictional question first. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 93-102 (1998). For the court to bypass the Section 502(a) issue and resolve the case on Section 514 grounds would be, "by very definition, for [the] court to act *ultra vires*." *Id.* at 102.[4] In-

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[4] The court below addressed these questions in the correct order: only *after* concluding that Section 502(a) conferred jurisdiction but did not resolve all of the plaintiffs' claims did the court move on to Section 514(a). *See* Brief for Respondent Aetna Health Inc. at 3-4, *Roark v. Humana, Inc.*, No. 02-1826 (filed July 7, 2003). Likewise, if this Court grants review in this case and concludes that some but not all aspects of Davila's claim are completely preempted, it would then be able to address the Section 514 defense that Aetna pressed in the courts below.

deed, prudential considerations also support examining the potentially dispositive Section 502(a) issue first. As this Court has previously held, a conflict with a *substantive* portion of ERISA (such as Section 502(a)'s exclusive remedial provisions) obviates any need to examine whether a state law also transgresses the more diffuse directives of Section 514. *See Boggs v. Boggs*, 520 U.S. 833, 841, 844 (1997).

For this reason, this Court should grant review in a case that presents the Section 502(a) question. This question is most directly presented in this case and its companion, *CIGNA Healthcare of Texas, Inc. v. Calad*, No. 02-83 (a case that largely incorporates the arguments presented in the petition in this case); it is also presented in *Cicio*, No. 02-69, and superficially in *Conover v. Aetna Inc.*, No. 02-1864 (although the petition in the latter case fails to argue, and thus waives, the Section 502(a) issue). In *Cicio*, the HMO excluded the proposed treatment under the terms of the plan on the ground that it was "experimental," as distinct from "unnecessary." 321 F.3d at 88. Accordingly, *Cicio* does not present the Section 502(a) issue in the factual context in which it most frequently arises, and this Court's resolution of *Cicio* might provide less relevant guidance to the lower courts dealing with "medical necessity" questions than would the disposition of this case. Nonetheless, we believe that both *Cicio* and *Calad* are better vehicles for the resolution of the questions that currently divide the federal courts of appeals than is *Roark*. In the event the Court elects not to give plenary consideration to (or summarily reverse) the judgment in this case, we respectfully suggest that certiorari should be granted in *Cicio* or *Calad*.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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No. 02-1845

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

SUPPLEMENTAL BRIEF FOR PETITIONER

Pursuant to this Court's Rule 15.8, petitioner Aetna Health Inc. ("Aetna") respectfully submits this supplemental brief to call the Court's attention to a newly decided case that highlights the circuit conflict addressed in the petition. The Third Circuit's recent decision in *DiFelice v. Aetna U.S. Healthcare*, No. 02-3381 (Oct. 15, 2003), is available at http://www.ca3.uscourts.gov/opinarch/023381p.pdf and is reproduced in the Appendix, *infra*.

1. In *DiFelice*, the Third Circuit considered a claim very similar to respondent's, and reached a conclusion directly contrary to the Fifth Circuit's in the decision below. DiFelice alleged that the administrator of his HMO, Aetna U.S. Healthcare ("AUSHC"), denied coverage for a specially designed tracheostomy tube because it was not "medically necessary" under the terms of his plan. DiFelice alleged that he suffered adverse effects from the standard tube for which AUSHC did approve coverage. He sued AUSHC under state tort law, claiming that the decision not to cover the special tube constituted negligent interference with his medical care. App., *infra*, 3a-5a.

The Third Circuit held that the claim based on the refusal to cover the specialized tube was completely preempted by ERISA § 502(a). App., *infra*, 18a. The court of appeals had held in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), that when a plan administrator's decision has elements of both medical treatment and coverage determination, and when the plan beneficiary could challenge that determination under ERISA's exclusive remedial provision, any additional state-law claim is completely preempted. App., *infra*, 10a-11a; *see also* Pet. 21-22 (discussing *Pryzbowski*). As in *Pryzbowski*, the court of appeals concluded that the insurer's decision was such a "mixed" decision and "[c]learly" could have been challenged by bringing an en-

forcement action under ERISA § 502(a)(1)(B). App., *infra*, 12a. The Third Circuit therefore concluded that DiFelice's claim regarding the special tube was completely preempted. *Id.* at 18a.

2. As *DiFelice* illustrates, the Third Circuit, like the majority of circuits, holds that ERISA § 502(a) provides the exclusive means of challenging an HMO's determination that a medical treatment is not covered because it is not medically necessary. The minority view—exemplified by the decision below, with which the *DiFelice* court expressly disagreed—rejects that exclusivity. *See* App., *infra*, 15a n.3.

The *DiFelice* court recognized that the circuits are sharply divided on this issue, requiring a resolution by this Court. Judge Rendell's majority opinion expressly observed that "other federal courts of appeals have followed different paths in determining whether a claim is preempted under section 502(a)." App., *infra*, 15a n.3. In addition, two judges filed concurrences stressing the need for this Court's review. App., *infra*, 21a (Becker, J., concurring) ("add[ing his] voice to the rising judicial chorus" urging action by this Court or Congress); *id.* at 49a (Ambro, J., concurring) ("join[ing] the chorus"). As Judge Rendell put it, the ERISA preemption analysis "seems to have taken on a life of its own, and not a very satisfying or productive life at that." *Id.* at 7a. This Court's review is warranted to put an end to this confusion.

3. *DiFelice* directly conflicts with the decision below. Both DiFelice and Davila were denied coverage for their preferred course of treatment, and both brought state-law tort claims alleging harm from the alternative, covered treatment that they underwent instead. App., *infra*, 3a-4a; Pet. 3-4 & n.2; Pet. App. 4a-5a. The Fifth Circuit in this case held that a state-law claim based on such a medical coverage decision is not completely preempted unless it "duplicate[s]" an ERISA action in every respect, including requesting the same type of damages. Pet. App. 17a, 20a. The Third Circuit, by contrast,

rejected such an invitation to artful pleading, *see* App., *infra*, 10a-11a, and recognized that the proper complete-preemption inquiry is "whether the actual alleged wrongdoing underlying the cause of action *could have formed the basis* of a suit under [ERISA § 502(a)]." *Id.* at 11a (emphasis added). Although, as the petition sets out, the circuits were already divided on this issue, the divergent resolution of identical claims in *DiFelice* and the decision below makes clear that this conflict is fully mature and should not go unaddressed.

DiFelice also demonstrates that this case presents the best vehicle among the several petitions currently pending for resolving this conflict. "Medical necessity" determinations, such as those at issue in both *DiFelice* and this case, represent the most frequently recurring type of dispute between plan administrators and beneficiaries. The Court should resolve the scope of ERISA preemption in this context, rather than in some other (such as the experimental treatment at issue in *Vytra Healthcare v. Cicio*, No. 03-69) that might not lead to a definitive resolution of the debate that has divided the courts of appeals. This case provides the Court with the opportunity, once and for all, to decide whether plan beneficiaries may mount state-law challenges to medical necessity determinations by HMO administrators. As the three opinions in *DiFelice* confirm, that issue cries out for this Court's resolution.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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October 16, 2003

APPENDIX

PRECEDENTIAL

Filed October 15, 2003

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 02-3381

JOSEPH V. DIFELICE, JR.,
Appellant

v.

AETNA U.S. HEALTHCARE; MICHAEL PICARIELLO, M.D.; SARAH FOWLER; EAR NOSE & THROAT ASSOC. OF CHESTER COUNTY, INC.; CHESTER COUNTY HOSPITAL

Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. Civil No. 02-cv-03641)
District Judge: Honorable John P. Fullam

Argued March 14, 2003

Before: BECKER, *Chief Judge,*[*]
RENDELL and AMBRO, *Circuit Judges.*

(Filed October 15, 2003)

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[*] Judge Becker completed his term as Chief Judge on May 4, 2003.

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OPINION OF THE COURT

RENDELL, Circuit Judge.

We are once again called upon to determine whether a lawsuit claiming medical negligence is completely preempted by the civil enforcement provision of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a). Joseph V. DiFelice, Jr., appeals the order of the United States District Court for the Eastern District of Pennsylvania dismissing his complaint against Aetna/U.S. Healthcare, Inc. ("Aetna") for negligent conduct in regard to his medical treatment for sleep apnea and upper airway obstruction. DiFelice filed suit in state court, alleging that Aetna's instruction to his treating physician that a specially designed tracheostomy tube was "medically unnecessary" and Aetna's insistence that he be discharged from the hospital before his attending physician deemed it appropriate amounted to negligent conduct under state law. Aetna removed the case to federal court on the basis of ERISA preemption and then moved to dismiss the claim. The District Court, relying on our decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), held that the claim was completely preempted and dismissed it in its entirety. For the reasons that follow, we will affirm in part and reverse in part.

DiFelice participates in an ERISA-governed employee welfare benefit plan that is administered by Aetna, a health maintenance organization ("HMO"). Under the terms of this plan, DiFelice is entitled to certain "Covered Benefits." Unless there is a specific provision for a particular type of treatment, a benefit is only covered if, in the determination of Aetna, it is "Medically Necessary." "Medically Necessary" is a defined term, meaning the service or supply must be "care or treatment as likely to produce a significant positive

outcome as, and no more likely to produce a negative outcome than, any alternative service or supply;" must be "related to diagnosis of an existing; illness or injury;" may "include only those services and supplies that cannot be safely and satisfactorily provided at home;" and, "as to diagnosis, care and treatment[, must] be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply."

In March 2001, DiFelice was diagnosed with "sleep apnea/upper airway obstruction," for which he required a tracheostomy tube.[1] His doctor, Dr. Michael Picariello, surgically inserted a tracheostomy tube to eliminate the obstruction, but that tube continually came out. Dr. Picariello then placed an order for a specially designed tube. However, Aetna instructed Dr. Picariello that the special tube was "medically unnecessary." Instead of ordering the special tube, the doctor then inserted a different tube, which caused DiFelice severe pain and resulted in an infection. DiFelice was later admitted to Chester County Hospital for treatment, but, the complaint avers, was thereafter discharged "at Aetna's insistence."[2]

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[1] Our recitation of the facts is derived from DiFelice's complaint.

[2] DiFelice objects to our consideration of the terms of the Plan in determining whether his complaint should be dismissed because he does not reference the Plan in his complaint, and Aetna did not argue below that the Plan provisions were dispositive. However, in ruling on a motion to dismiss, we may consider an extrinsic document that is "integral" to the complaint. *See In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997). Here, DiFelice's reference to "medical necessity" is clearly derived from the terms of the Plan. Furthermore, even if Aetna did not explicitly argue that the Plan provisions controlled the decision in this case, Aetna attached the Plan as an exhibit to its brief and motion before the District Court. DiFelice was certainly on notice that the Plan terms were integral to Aetna's argument.

DiFelice filed a five-count complaint in the Philadelphia Court of Common Pleas against Aetna, his treating physicians, and the hospital. In Count I, he alleged that Aetna negligently interfered with his medical care "by instructing Dr. Picariello that the specially designed tracheostomy tube he deemed necessary was medically unnecessary for [DiFelice] and improperly interfering with Dr. Picariello's medical decision concerning the tracheostomy tube and insisting on [DiFelice's] discharge from the [hospital] . . . before his attending physician was planning on discharging [him]." The other counts involved claims against parties other than Aetna. Aetna removed the case to the District Court on the grounds that the claim against it was completely preempted under ERISA and then moved to dismiss. DiFelice opposed the motion to dismiss and moved to remand to state court.

The District Court denied DiFelice's motion to remand and granted Aetna's motion to dismiss as to Count I, and granted the motion to remand on the remaining counts against the other parties. The Court held that the disposition of Count I was "squarely controlled by the Third Circuit's decision in *Pryzbowski*," in which we held that a claim challenging the "administration of or eligibility for benefits" was completely preempted by section 502(a)(1)(B) of ERISA. *Pryzbowski*, 245 F.3d at 273. The Court reasoned that the claim against Aetna was completely preempted because DiFelice was challenging Aetna's decision that he was not entitled to the special tube under the Plan, which was entirely a matter of administration, and because Aetna was not actually involved in providing any medical services to DiFelice. DiFelice appeals the District Court's order dismissing Count I.

We have jurisdiction over the District Court's final order pursuant to 28 U.S.C. § 1291, and review the Court's exercise of jurisdiction and order of dismissal de novo. *Pryzbowski*, 245 F.3d at 268. Aetna bears the burden of proving the federal jurisdiction it seeks. *Spectacor Mgt. Group v. Brown*, 131 F.3d 120, 127 (3d Cir. 1997). In reviewing the complaint, we must accept as true all of DiFelice's factual allegations and draw all reasonable inferences therefrom. *Langford v. City of Atlantic City*, 235 F.3d 845, 847 (3d Cir. 2000).

DiFelice challenges the District Court's removal jurisdiction over Count I of his complaint and asks us to remand to state court. He argues that his negligence action against Aetna is entirely a matter of state law and provides no basis for removal. Aetna counters that DiFelice's negligence action is in fact nothing more than an action to recover benefits due under his plan, and as such is completely preempted by the civil enforcement provision of ERISA, section 502(a).

A. Framework

Under the "well-pleaded complaint" rule, federal question jurisdiction only exists where an issue of federal law appears on the face of the complaint. *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 24 (1983). However, there is an exception to this rule: when a purportedly state-law claim "comes within the scope of [an exclusively] federal cause of action," it "necessarily 'arises under' federal law," and is completely preempted. *Id.*; *see also Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062 (2003) (explaining the preemptive effect of ERISA). The question before us is therefore whether DiFelice's claims of state law negligence on the part of Aetna fall within the scope of the federal causes of action provided in section 502(a) of ERISA, that is, whether the claims could have been brought under that section. If so, then the existence of the federal claim would provide the basis for federal question

jurisdiction but at the same time would require dismissal based on complete preemption.

We have had numerous occasions to consider the question of whether a plaintiff's claim against an HMO is covered by section 502(a) and is therefore completely preempted. *See, e.g.*, *Pryzbowski*, 245 F.3d at 273-75; *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 250 (3d Cir. 2000); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162-63 (3d Cir. 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995). Determining whether a claim could have been brought under ERISA has proven to be anything but an exact science. In fact, as my colleagues' concurring opinions point out all too well, the exercise seems to have taken on a life of its own, and not a very satisfying or productive life at that. In any event, the statute and our case law chart the path we must follow.

Section 502(a) allows for civil actions to be brought "by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). The line between an action to recover benefits, which challenges an administrative decision regarding whether a certain benefit is covered under an ERISA plan, and an action alleging negligence or malpractice, which challenges the medical treatment actually provided to a patient, is a blurry one. We have been continually refining the precise test we use in evaluating such claims.

Most recently, in *Pryzbowski*, we synthesized the discussions contained in our previous opinions and adopted preferable new terminology. We explained that in the past we had attempted to distinguish between claims directed at the *quality* of benefits received—that is, as to the treatment—which would not fall within section 502(a), and claims that the plans erroneously withheld a *quantum* of benefits due—focusing on the administration of the plan—which would be completely preempted. *Pryzbowski*, 245 F.3d at 272. Fol-

lowing this "quality-quantity" rubric, we had held that an allegation that an HMO had failed to exercise reasonable care in providing medical treatment was not preempted, *Dukes*, 57 F.3d at 358; an allegation that an HMO's policy of discharging newborns within 24 hours after their delivery was essentially a medical determination and was not preempted, *In re U.S. Healthcare*, 193 F.3d at 163; and an allegation that an HMO's financial disincentives discouraged medical providers from hospitalizing a mentally ill woman was a "quality of care" claim because it occurred in the course of a treatment decision, and was therefore not preempted. *Lazorko*, 237 F.3d at 250.

However, in *Pryzbowski*, we found the "quality-quantity" distinction unclear, and suggested that more helpful terminology was utilized by the Supreme Court in *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although we recognized that *Pegram* "concerned fiduciary acts under ERISA and not preemption," we found useful "the distinction made there between *eligibility decisions*, which turn on the plan's coverage of a particular condition or medical procedure for its treatment," and "*treatment decisions*, which are choices in diagnosing and treating a patient's condition," and determined that the distinction was "equally applicable for complete preemption analysis." *Pryzbowski*, 245 F.3d at 273 (quoting *Pegram*, 530 U.S. at 228) (emphasis added and internal quotations omitted). We then explained,

> Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

Id.

Using this nomenclature, it was evident to us in *Pryzbowski* that "a claim alleging that a physician knowingly delayed in performing urgent surgery . . . would relate to the quality of care," while on the other hand, "a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits." *Id.* (citing *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996)). However, we were presented there with claims that fell somewhere in between: that an HMO had negligently delayed approval of an out-of-network specialist, and that it had failed to supervise properly its employees to make "thoughtful and reasonable decisions as to healthcare." *Id.* at 274. Were those claims based on a treatment decision or on a determination as to eligibility for a benefit? We explained that "[i]n analyzing whether a claim falling between the[ ] two poles is completely preempted, it is necessary to refer to § 502(a)." *Id.* at 273. Paring the issue down to its essence, we stated that the relevant question must be whether the claim "could have been the subject of a civil enforcement action under § 502(a)." *Id.* If it could have, then it was a plan benefit claim, and Congress has clearly expressed its intent that the claim be preempted by ERISA. *Id.* (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)).

Because the claims in *Pryzbowski* fell between the two poles, we took extra care to examine the complaint for "artful pleading," to ensure that Pryzbowski was not disguising an eligibility claim that could have been brought under ERISA as a state law negligence claim. We explained that, although the claim might be "ostensibly directed at the provision of medical treatment," we needed to "look beyond the face of the complaint to determine whether [Pryzbowski had] artfully pleaded his suit so as to couch a federal claim in terms of state law." *Id.* at 274 (quoting *Jass*, 88 F.3d at 1488); *see also Franchise Tax Bd.*, 463 U.S. at 22 ("[A] plaintiff may

not defeat removal [to federal court] by omitting to plead necessary federal questions in a complaint."). The ultimate question was whether, when the basis for the claim was properly understood, the claim fell under ERISA.

After carefully examining Pryzbowski's complaint for the true bases of his claims, we held that his claims were completely preempted. First, regarding the delayed approval, we concluded that underlying the HMO's allegedly negligent activities was a policy decision regarding payment to and approval of out-of-network specialists, a decision that fell "within the realm of the administration of benefits." *Pryzbowski*, 245 F.3d at 273. We explained that this claim could have been brought under ERISA because "[h]ad Pryzbowski sought to accelerate [the HMO]'s approval of the use of out-of-network providers, she could have sought an injunction under § 502(a) to enforce the benefits to which she was entitled under the plan." *Id.* at 273-74. Further, her claim that the HMO had "failed to properly hire, train, and supervise its employees to make thoughtful and reasonable decisions as to healthcare" was also preempted because, reading behind the artful "medical negligence" pleading, the complaint did not allege that the HMO or its employees had actually engaged in any medical treatment. *Id.* at 274. Because the HMO's only role was in administering Pryzbowski's benefits, it could not possibly have been negligent in providing treatment. *Id.* Unlike the situation in which an HMO fills dual roles as an administrator of benefits *and* a provider of services, and might therefore actually engage in medical treatment, the HMO there was acting *solely* as an administrator. *Id.*

Pryzbowski thus instructs us to determine whether a claim is preempted under section 502(a) by first examining whether the claim falls at either of the two poles, entirely treatment or entirely administrative. If based solely on a medical treatment decision, then the claim is not preempted. If based on an HMO administrator's eligibility decision, then

the claim is preempted. In the more difficult situation in which the claim falls somewhere in between, we must scrutinize the complaint for "artful pleading," and then refer to section 502(a) itself and determine whether the actual alleged wrongdoing underlying the cause of action could have formed the basis of a suit under that section.

As discussed more fully below, when we apply the *Pryzbowski* framework to the complaint before us, we conclude that DiFelice's claim that Aetna "interfered with" his medical treatment by declaring the special tube "medically unnecessary" is preempted by ERISA because it could have been brought as an action under section 502(a). However, because it appears that DiFelice's claim that he was discharged "at the insistence of Aetna" does not rest on any discharge policy set forth in the Plan, or any agreed benefit, it would not be encompassed within the relief available under section 502(a) and is therefore not completely preempted.

B. The Tracheostomy Tube

We will first examine DiFelice's claim that Aetna interfered with Dr. Picariello's medical decision regarding the special tube. Under *Pryzbowski*, the first question is whether Aetna's "medical necessity" determination is clearly either a medical treatment decision or an eligibility decision. DiFelice has couched this claim in terms of Aetna's negligent interference with his care, which seems to imply that Aetna itself engaged in medical treatment. However, DiFelice's complaint does not include any allegation that Dr. Picariello was an agent of Aetna, that Aetna did not exercise reasonable care in monitoring Dr. Picariello's care, or that Aetna itself provided medical treatment; rather, his claim rests on Aetna's "instruction" to Dr. Picariello "that the specially designed tracheostomy tube he deemed necessary was medically unnecessary," a direct reference to the "medical necessity" determination called for in the Plan. Looking behind DiFelice's use of language sounding in negligence, he is alleging that

Aetna wrongfully denied him coverage for the special tube. Thus, the complaint has aspects of treatment and coverage. That is, in making its determination, Aetna necessarily had to exercise some medical judgment, i.e., it had to determine whether the special tube was "as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, . . . [was] related to diagnosis of an existing illness or injury, . . . [and was] no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply." However, here there is no allegation that Aetna actually provided the medical care, and Aetna's use of medical judgment could only have led to an eligibility, not a treatment, decision.

Because the decision here was in some sense both a medical treatment and an eligibility decision, thus falling between the two poles discussed in *Pryzbowski*, we must refer to section 502(a) and determine whether DiFelice's claim regarding the tube could have been the subject of a civil enforcement action under ERISA. *Pryzbowski*, 245 F.3d at 273. Clearly, it could have been. DiFelice could have challenged Aetna's "medical necessity" determination by filing a claim under 502(a)(1)(B) "to recover benefits due to him under the terms of his plan," and arguing that the special tube was in fact "medically necessary," and was therefore a "covered benefit." He could have requested an injunction forcing Aetna to pay for the special tube, or alternatively, paid for the tube himself and then later filed an action for reimbursement. Numerous ERISA participants have in fact brought such actions challenging their HMO's "medical necessity" determinations and seeking to recover benefits they alleged were due under their plans. *See, e.g.*, *Mario v. P&C Food Mkts., Inc.*, 313 F.3d 758, 762-63 (2d Cir. 2002) (reviewing claim under section 502(a) challenging HMO's determination that sex change operation was not "medically necessary"); *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 814-15 (7th Cir. 2002) (reviewing claim under section 502(a) challenging HMO's determination that custodial care was not "medically necessary"); *Kopicki v. Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467, 480 (D. Md. 2000) (granting preliminary injunction to prevent HMO from denying preauthorization for cancer treatment it had deemed not "medically necessary"); *see also Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1253 (3d Cir. 1993) (reviewing claim under section 502(a) challenging an HMO's determination that a liver/pancreas treatment was an "experimental procedure"). DiFelice's claim falls squarely within this jurisprudence. Because DiFelice's claim that Aetna improperly deemed his special tube to be "medically unnecessary" could have been brought under section 502(a), it is completely preempted by ERISA. We will therefore affirm the District Court's exercise of removal jurisdiction and its order dismissing Count I as to Aetna's conduct regarding the tracheostomy tube.

DiFelice urges that this result is inconsistent with the Supreme Court's decision in *Pegram* and our decisions in *U.S. Healthcare* and *Lazorko*. We disagree.

In *Pegram*, the Supreme Court answered the question whether an HMO may be liable for a breach of fiduciary duty when its physician owners make "mixed eligibility and treatment decisions." *Pegram*, 530 U.S. at 229. There, a physician, who was also an owner of the HMO that covered her patient, waited to order an ultrasound for the patient's inflamed appendix, and the appendix ruptured. *Id.* at 215. The patient sued the HMO for breach of fiduciary duty, alleging that the HMO created an incentive for the physicians to make decisions in their own financial interests, rather than in the exclusive interests of the plan participants. *Id.* The Court held that HMOs do not act as "fiduciaries" as envisioned by ERISA when their physician owners make deci-

sions that touch both on the patient's medical treatment and the patient's eligibility for benefits under the plan. *Id.* at 218.

The Court first set forth a framework for understanding the kinds of acts that physician owners acting on an HMO's behalf might undertake. On the one hand are "pure 'eligibility decisions'" turning on the plan's coverage for a particular medical treatment, and on the other are "treatment decisions," choices about how to go about diagnosing and treating a patient's condition. *Id.* at 228. In between are situations in which the "eligibility decision and the treatment decision [are] inextricably mixed," that is, when an eligibility decision necessarily rests on the "physicians' judgments about reasonable medical treatment." *Id.* The Court found that it was presented with just such a "mixed" decision: the physician owner had determined that the patient's "condition did not warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover immediate care." *Id.*

Having concluded that the decision before it was a "mixed" decision, the Court went on to hold that an HMO's physician owners do not act as fiduciaries under ERISA when making such decisions. *Id.* at 231. The Court focused on the nature of "fiduciaries," explaining that these mixed decisions are not "fiduciary in nature," and bear "only a limited resemblance to the usual business of trustees." *Id.* The Court feared that a contrary result would open the floodgates to malpractice suits against HMOs and individual physicians under the guise of ERISA breach of fiduciary duty claims, and would erode the distinction between state malpractice and federal ERISA actions. *Id.* at 235-36.

Although, as we noted above, *Pegram* set forth helpful terminology for preemption analysis, *see Pryzbowski*, 245 F.3d at 273, the Court's holding that a "mixed" determination made by a physician owner does not subject an HMO to liability for breach of fiduciary duty does not translate to, or

govern in, the preemption context. Rather, *Pegram* sets a standard for when liability is to be imposed on individuals acting in a fiduciary capacity. It does not presume to encompass ERISA claims enforcement as such. In fact, the *Pegram* Court specifically stated that it was not discussing the standards governing a claim that a patient had been wrongfully denied benefits due under a plan nor the interaction between such a claim and state law causes of action. *Pegram*, 530 U.S. at 229 n.9; *accord Roark v. Humana, Inc.*, 307 F.3d 298, 308 (5th Cir. 2002) (stating that the Supreme Court has not decided whether section 502(a)(1)(B) preempts a medical malpractice claim involving "mixed decisions," but holding under Fifth Circuit law that it does not). In fact, it could be argued that allowing plaintiffs to do an end-run around ERISA by permitting them to couch *plan decisions* that have some impact on treatment in negligence terms would have a similar effect of undermining ERISA as was feared by the Court in *Pegram*. We remain convinced that, after *Pryzbowski*, we look at what decisions are subject to enforcement, which is a radically different inquiry from when can an HMO be sued for breach of fiduciary duty.[3]

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[3] We note that other federal courts of appeals have followed different paths in determining whether a claim is preempted under section 502(a). Some have concluded, on the facts before them, that a suit challenging a "medical necessity" determination was preempted, *see Marks v. Watters*, 322 F.3d 316, 326-27 (4th Cir. 2003) (holding that a suit against an HMO utilization review case manager was completely preempted under section 502(a) because the HMO did not actually provide medical treatment); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489 (7th Cir. 1996) (holding that a negligence claim against an HMO utilization review case manager was completely preempted because the claim was "in effect a claim for denial of benefits"), and some have concluded that it was not. *See Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1293 (11th Cir. 2003) (holding that claims that an

We are also not persuaded that *U.S. Healthcare* and *Lazorko*—both of which pre-date *Pryzbowski* and rely on the "quality-quantity" distinction—compel a different result. In *U.S. Healthcare*, we held that a suit against an HMO challenging its policy of pre-certifying a twenty-four hour discharge of mother and newborn was not preempted by ERISA because it went to the quality of the health care provided. *U.S. Healthcare*, 193 F.3d at 162. Significantly, we noted that the plaintiffs did not allege "a failure to provide or authorize benefits under the plan," nor did they claim "that they were denied any of the benefits that were due under the plan." *Id.* Rather, they alleged that the HMO was negligent in adopting the discharge policy and in supervising the physicians with whom they contracted for services, and that the HMO's incentive structure adversely affected the physicians' medical judgment regarding when newborns should be discharged. The plaintiffs were not seeking to enforce benefits they thought were due to them under the plan; they were challenging the discharge policy itself and the HMO's actions "in its role as a provider or arranger of medical ser-

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HMO failed to correctly diagnose a condition and authorize proper medical treatment were tort claims outside of the scope of section 502(a)); *Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003) (concluding that under *Pegram*, a state law medical malpractice action based on a "mixed" decision is not preempted by ERISA when the state law cause of action "challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms"); *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002) (holding that a claim that an HMO had failed to use ordinary care in making a medical necessity determination sounded in tort and was not preempted). We believe that the framework we set forth in *Pryzbowski* provides the controlling method of analysis here and compels the conclusion that DeFelice's claim regarding the tube is preempted.

vices," not in its role as administrator of benefits. *Id.* at 163. The HMO's "policy and incentive structure were such that the [patients] never had the option of making an informed decision as to whether to pay for the hospitalization themselves, as would occur in a situation in which coverage is sought and denied." *Id.* Although we analyzed the claims in *U.S. Healthcare* under the "quality-quantity" rubric, our holding squares with the preemption framework we later set forth in *Pryzbowski*. Because the plaintiffs in *U.S. Healthcare* were not suing for any benefits due under the plan, but rather were challenging the plan itself, they could not have sued under section 502(a), and therefore, even under *Pryzbowski*, their claims would not have been preempted.

Lazorko involved a similar issue. There, we held that a claim that financial disincentives imposed by an HMO discouraged medical providers from hospitalizing a patient who later committed suicide was a "quality of care" claim and therefore not preempted. *Lazorko*, 237 F.3d at 249-250. We noted that Lazorko was not claiming that the HMO plan was supposed to include hospitalization, but rather that her doctor was influenced in his decision-making by the incentive structure. *Id.* As in *U.S. Healthcare*, the patient could not have sued under ERISA because she never had the option of seeking continued hospitalization—her doctor, as influenced by the HMO policy, did not offer it to her. *Id.*

Unlike in *U.S. Healthcare* and *Lazorko*, here, DiFelice is suing based on denial of a benefit he claims he was due under the Plan. He is not claiming that Aetna negligently adopted a particular policy regarding tracheostomy tubes or imposed an incentive structure that interfered with his physician's independent medical judgment. Rather, he claims that the special tube was not "medically unnecessary," and that Aetna wrongfully determined that it was, a claim that is based on the language of the Plan and pertains to the nature of benefits provided. Unlike the plaintiffs in *U.S. Healthcare* and *La-*

zorko, DiFelice sought and was denied coverage for a benefit, and could have paid for the benefit himself and sued under section 502(a) for reimbursement.

Because under our most recent controlling precedent, *Pryzbowski*, DiFelice's claim that Aetna was negligent in determining that the special tube was "medically unnecessary" could have been the subject of a suit under section 502(a) for benefits due under the Plan, his claim is preempted by ERISA.[4] We will therefore affirm the District Court's exercise of removal jurisdiction and subsequent dismissal of the claim with respect to the tube.

C. The Discharge from the Hospital

Count I also includes a claim that Aetna improperly interfered with DiFelice's medical treatment by "insisting on [his] discharge from the [hospital] . . . before his attending physician was planning on discharging [him]." The District

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[4] Aetna argues that the Supreme Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), compels this result, but we find that case to be inapposite. The Court in *Moran* was faced with an Illinois statute that provided HMO participants "with a right to independent medical review of certain denials of benefits," *id.* at 359, and required HMOs to provide any service that the independent reviewing physician deemed "medically necessary." *Id.* at 361. The Court held that "it was beyond serious dispute" that the statute "related to" an ERISA plan and was therefore preempted under 29 U.S.C. § 1144(a), but went on to hold that the statute was saved from preemption under 29 U.S.C. § 1144(b)(2)(A) because it regulated insurance. *Id.* at 365-66. Thus, the Court was not faced with the question of whether a suit challenging an HMO's medical necessity determinations would be preempted under ERISA absent a particular state statute that imposed additional burdens on the HMO, which is the issue before us here.

Court did not address this aspect of the claim in its order dismissing the complaint.

Unlike his claim regarding the tracheostomy tube, DiFelice does not allege that Aetna deemed the hospital stay to be "medically unnecessary" and therefore not covered by the Plan. The claim also does not appear to rely on a discharge policy in the Plan or any agreed benefit. Indeed, it is difficult to tell from DiFelice's vague pleadings what precisely he is alleging that Aetna did or the form this "insistence" took. If Aetna in some way forced the hospital to discharge him, or imposed financial incentives like those in *U.S. Healthcare* and *Lazorko* that unduly affected his physician's judgment, then DiFelice has pled a negligence cause of action that is not preempted by ERISA.

At the dismissal stage, it was Aetna's burden to prove federal jurisdiction by proving that this is ăn ERISA claim. *See Spectacor Mgt. Group*, 131 F.3d at 127. There is nothing apparent from the pleadings that would foreclose DiFelice from being able to prove that the discharge decision was not a plan benefit. Unlike his claim that the tube was erroneously determined to be "medically unnecessary" under the Plan, this claim on its face is not plan-related. Therefore, because DiFelice's claim of "insistence" on the discharge could give rise to state law negligence liability, we hold that it is not completely preempted by section 502(a) of ERISA.

Aetna argues that, even if DiFelice's hospital discharge claim is cognizable as a state law cause of action, we should uphold the District Court's dismissal of that claim on the alternative ground that it is nonetheless expressly preempted by virtue of section 514 of ERISA, 29 U.S.C. § 1144(a), which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. However, "[u]nlike the scope of § 502(a)(1)(B), which is jurisdictional and creates a basis for removal to federal court, § 514(a) merely governs

the law that will apply to state law claims, regardless of whether the case is brought in state or federal court." *Lazorko*, 237 F.3d at 248. As we have determined that the hospital discharge claim is not preempted by section 502(a), we do not have jurisdiction over that claim. Rather, the question of whether the hospital discharge claim will be controlled by federal law pursuant to section 514 must be decided by the District Court on remand, should it choose to exercise supplemental jurisdiction under 28 U.S.C. § 1367(a), or by the state court. *See Pryzbowski*, 245 F.3d at 276 (where District Court has jurisdiction over one claim by virtue of preemption under section 502(a), it has discretion to decide whether to exercise supplemental jurisdiction over claims arising from the same factual predicate or remand to state court).

Because DiFelice's claim that Aetna interfered with his medical treatment by finding the special tracheostomy tube to be "medically unnecessary" could have been brought under section 502(a) of ERISA for the recovery of benefits due under his plan, it is completely preempted. We will therefore affirm the order of the District Court dismissing that claim. However, because Aetna has not shown that DiFelice's claim that Aetna interfered with his medical treatment by insisting on his discharge from the hospital is based on any plan benefit, that claim is not completely preempted. We will therefore reverse the District Court's order dismissing that claim and remand for further proceedings.

BECKER, *Circuit Judge*, concurring.

I am satisfied that Judge Rendell's opinion reaches the correct result under our governing caselaw. While I thus join in her opinion and in the judgment, I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime.

Congress enacted ERISA in 1974 "to promote the interest of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983) (surveying Congressional statements of purpose). However, with the rise of managed care and the Supreme Court's series of decisions holding preempted any action for damages against HMOs, ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries, a state of affairs that I view as directly contrary to the intent of Congress. Indeed, existing ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess.

Lower courts have struggled to maintain some semblance of equity notwithstanding the enormous breadth of the preemption test, one that turns on whether the claim is "related to" a benefit plan, *inter alia*, by identifying exceptions to § 514 preemption, such as that for medical malpractice liability. And in terms of the remedial scope of § 502, they have struggled to make sense out of the distinction between eligibility decisions (which are preempted) and medical decisions (which are not), a hopeless endeavor, as I shall explain. Unfortunately, the price of all this has been descent into a

Serbonian bog[1] wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases.

I.

A.

ERISA was enacted in 1974 to address the increasingly-apparent insecurity of workers' vested pension funds, a problem that gained national recognition through such notorious events as the Studebaker plant shutdown in 1963, which caused approximately 4,400 workers to lose their pensions. *See generally* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, U.S. Senate, Special Comm. on Aging, The Employee Retirement Income Security Act of 1974: The First Decade 6-25 (Information Paper) (1984). Prior to ERISA, workers were entitled only to the assets in the pension plan or to nominal pension benefits, whichever was lower; of course, it was entirely possible for a plan to have zero assets, as happened with some frequency when firms closed shop. ERISA contained a raft of provisions designed to protect plan participants against negligent or malfeasant plan managers. For example, it created the Pension Benefit Guarantee Corporation ("PBGC"), an insurer akin to the Federal Deposit

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[1] A Serbonian bog is a mess from which there is no way of extricating oneself. E. Cobham Brewer, *The Dictionary of Phrase and Fable* 1121-22 (First Hypertext ed.). The Serbonian bog itself was between Egypt and Palestine. Strabo called it a lake, and said it was 200 stadia long, and 50 broad; Pliny made it 150 miles in length. Hume said that whole armies have been lost therein, as did Milton: "A gulf profound as that Serbonian bog, / Betwixt Damiata and Mount Cassius old, / Where armies whole have sunk." Milton, *Paradise Lost*, ii. 592.

Insurance Corporation, to protect against employer insolvency.

The "benefit plans" in need of protection, however, were of two distinct types—pension and welfare—and substantially different policy concerns animated Congress's reform in each area. Pension plans, to which employees contribute over the course of their careers and rely upon to provide retirement income, were thought to present far greater opportunity for mismanagement and underfunding. Unlike welfare benefit plans, pension plans accrue substantial funds that must be invested with prudence, and they must be able to survive continuously changing circumstances. Title 1 of ERISA therefore imposed on pension plan managers comprehensive reporting, disclosure, vesting, minimum funding, and fiduciary duty requirements.

Welfare benefit plans, which include medical, surgical, sickness, accident, disability, death, unemployment, and similar programs, posed a very different set of challenges. Unlike pension plans, welfare benefit plans operate on a "pay as you go" basis, and generally do not entail long-term financial commitments. *See* John H. Langbein and Bruce A. Wolk, *Pension and Employee Benefit Law* at 176 (3d ed. 2000). ERISA's framers therefore saw no need to impose vesting requirements on such plans. Similarly, minimum funding requirements are intended to guard against plan default by the plan sponsor on its long-term commitments to plan beneficiaries, a minor concern where no substantial funds accrue. The framers thus exempted welfare benefit plans from ERISA's funding requirements as well.

The result is that welfare benefit plans are far less regulated than pension plans. They are subject to ERISA's reporting, disclosure, fiduciary, and remedial rules—those that govern procedure—but exempt from the substantive vesting and funding requirements, which are meant to guarantee a certain level of expected benefits. Congress's relative lack of

concern with substantive regulation of welfare plans is clear from the Supreme Court's statement that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *Shaw*, 463 U.S. at 91. Indeed, courts have held that the absence of a vesting provision allows employers to amend their plans virtually at will, even in discriminatory fashion. *See, e.g., Confer v. Custom Engine Co.*, 952 F.2d 41, 43 (3d Cir. 1991) (noting a plan sponsor may change benefits prospectively by formal written notice); *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (upholding an employer's amendment of its plan to exclude coverage for AIDS treatment).

Despite ERISA's relatively light regulation of welfare benefit plans, it is clear that the legislation provided substantially greater safeguards for both pension and welfare plan beneficiaries than had previously existed. But ERISA also contained a crucial concession to plan sponsors in the form of § 514(a), an express preemption provision mandating that Titles I and IV of ERISA, which impose the regulations discussed above, "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Although this section is subject to an important exception that allows states to impose laws regulating insurance, *see* § 514(b)(2)(A), its breadth is striking. The Supreme Court explains that Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). This view is premised on the statement of Rep. John Dent, a sponsor of the Act in the House of Representatives, who declared that its purpose was to "eliminat[e] the threat of conflicting and inconsistent State and local regulation." 120 Cong. Reg. 29197 (1974).

B.

In a meaningful sense, Congress's decision to federalize pension and employee benefit law appear to have assisted plan beneficiaries as much as plan sponsors. No employer is required to offer a pension or welfare benefit plan to its employees, and were Congress to have established ERISA's regulations as merely a federal baseline and allowed states to supplement it as they saw fit, i.e., had ERISA not preempted state law, some employers might have declined to offer such plans rather than deal with the compliance costs of tailoring them to individual jurisdictions. At a minimum, it is likely that any compliance costs would have been reflected in a lower level of benefits for plan participants, which of course would undermine the purpose of ERISA. From an *ex ante* perspective, therefore, it might have been reasonable to view even § 514(a) as furthering the interests of plan beneficiaries.

In practice, however, nothing has been further from the truth—ERISA generally, and § 514(a) particularly, have become virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided. In these cases, which began with *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court initially employed textualist interpretations of § 514(a) to give ERISA a staggeringly broad preemptive scope. *Alessi* itself was a relatively straightforward case in

which a unanimous Court held preempted a New Jersey law that eliminated one method for calculating pension benefits, reasoning that, whatever the law's purpose, it clearly related to pension plans. *Id.* at 524. Although *Alessi* itself was innocuous enough, it established a precedent of determining ERISA's preemptive scope by searching the phrase "relates to" for concrete meaning, an approach that would eventually be chimerical.

In *Shaw v. Delta Air Lines*, 463 U.S. 85 (1993), another unanimous decision, two New York statutes required health and disability plans to treat pregnancy the same as other non-occupational disabilities at a time when federal employment discrimination statutes did not. In a landmark passage, the Court stated:

> We have no difficulty in concluding that the [New York laws] "relate to" employee benefit plans. The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. *A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.*

Id. at 96-97 (emphasis added). Although the Court left the door ajar by cautioning that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *id.* at 100, n.21, the "connection with or reference to" language became the test for future cases.

The Court applied the passage in unanimous holdings in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a state statute mandating mental health coverage in group health insurance policies fell within § 514(a)'s preemptive scope, but was saved by ERISA's insurance exception), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding preempted a state cause of action against an insurer for bad-faith denial of a claim). By the mid-1990s, however, it had become clear that the "relates to"

standard was one without conceptual limits, and given the Court's general "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress," *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), it balked at the specter of a preemptive vortex that could swallow virtually any state remedial law. It abruptly reversed course in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), where it unanimously noted that, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Id.* at 655 (internal citation omitted). It recognized that it "simply must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656.

C.

As discussed above, Congress's intent behind § 514(a) preemption was to ensure that plan sponsors would be subject to uniform law. *See Ingersoll-Rand*, 498 U.S. at 142. One critical aspect of this uniformity concerns § 502, ERISA's civil enforcement provision. In *Pilot Life*, the Court concluded that Congress intended the remedies in § 502 to be the *exclusive* remedies for violations of rights guaranteed under ERISA. It explained that "the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act. . . . Congress was well aware that the powerful pre-emptive force of § 401 of the LMRA displaced" all state law claims, "even when the state action purported to authorize a remedy unavailable under the federal provision." 481 U.S. at 52 53. In other words, § 514(a) preempts state causes of action to enforce ERISA-guaranteed rights even when § 502 provides no sub-

stitute federal cause of action. This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights, for the remedies contained in § 502 are incapable of making victims whole; indeed, in many cases they actually create incentives for HMOs to mistreat their plan participants.

Section 502 contains two subsections that address a participant's right to recover for wrongs committed against the participant personally (as opposed to those committed against the plan itself, which are considered violations of the sponsor's fiduciary duty). The first, § 502(a)(1)(B), authorizes the participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." It is through this provision that DiFelice might have sought an injunction to compel Aetna to cover the specialized tracheostomy tube. The second, § 502(a)(3), authorizes a participant, beneficiary, or fiduciary to seek equitable remedies—injunctive relief against "any act or practice which violates" ERISA or the plan terms, or "other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions" of ERISA or the plan.

Although these provisions seem comprehensive at first glance—they allow recovery of "benefits due" and empower a participant to "enforce his rights" and seek "appropriate equitable relief"—they in fact operate to leave participants almost completely at the mercy of HMOs. The first section, 502(a)(1)(B), by its plain language only allows plan participants to seek the benefits to which they are contractually entitled, even when those benefits have been denied in bad faith and despite the fact that the participants most in need of this section are often the ones least able to take advantage of it. A plan participant whose claim is denied by an HMO's utili-

zation review board—Mr. DiFelice, for example, *see infra*—is often in the throes of a life-or-death medical crisis, hardly a feasible time to retain counsel and prosecute an injunctive lawsuit. The costs of such suits are likely to be immense, and ERISA provides for attorney fees, if at all, only after the action concludes. *See* § 502(g)(1). Even if a participant ultimately prevails against his insurer, it will frequently be the participant's estate that reaps the meager reward.

In many areas of law contingency fee structures are used to overcome a litigant's initial impecuniosity. But any possibility of using contingency fees in this context is undermined by ERISA preemption, for a string of Supreme Court cases has interpreted ERISA to disallow any recovery of compensatory or punitive damages. *See* Langbein & Wolk, *Pension and Employee Benefit Law* at 770-75. In *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), the plaintiff sued under § 502(a)(2), alleging that the improper processing of her benefit claim exacerbated her condition and entitled her to compensatory and punitive damages under § 409(a), which, *inter alia*, authorizes "such . . . equitable or remedial relief as the court may deem appropriate." The Court, however, concluded that any recovery under § 409 must inure to the plan rather than the beneficiary. The Court then explained in dictum that § 502(a)(1)(B), the analogous section allowing for a participant's recovery, says "nothing about the recovery of extra-contractual damages." *Id.* at 144. In an oft-cited passage, it explained:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted [ ] provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent admission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent

> remedial scheme, which is in turn part of a comprehensive and reticulated statute.

Id. at 146 (internal citation omitted).

Although *Russell*'s narrow holding left open the possibility that extracontractual damages are recoverable under § 502(a)(3)'s "appropriate equitable relief" provision, the Court's subsequent decision in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), foreclosed any such hopes. In *Mertens*, participants sued the fiduciaries of a failed plan, alleging breach of fiduciary duty and seeking monetary relief, which they characterized as equitable. Petitioners argued that, "[a]lthough a beneficiary's action to recover losses resulting from a breach of duty superficially resembles an action at law for damages, . . . such relief traditionally has been obtained in the courts of equity and therefore is, by definition, equitable relief." *Id.* at 255-56.

The Supreme Court acknowledged that ERISA's roots lie in the common law of trusts, *see Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989), that courts of equity had jurisdiction over trust law, and that monetary damages were available in those courts against the trustee. It concluded, however, that "[s]ince *all* relief available for breach of trust could be obtained from a court of equity, limiting the sort of relief available under § 502(a)(3) to 'equitable relief' in the sense of 'whatever relief a common-law court of equity could provide in such a case' would limit the relief *not at all.*" *Mertens*, 508 U.S. at 257. Put another way, interpreting "equitable relief" to mean "any relief" would render superfluous the word "equitable." The Court's solution was to interpret "equitable" as referring to types of relief traditionally available in pre-merger courts of equity, that is, injunctions, mandamus, and restitution, but not monetary damages.

The unavailability of extracontractual damages has effects that are perverse. First, as stated above, contingency

fees are rendered entirely impractical—precious few lawyers would be willing to undertake a horrendously complex case of uncertain outcome when the greatest potential reward is merely provision of the care that had been contractually promised. Without contingency fees, participants in the midst of medical crises are completely at the mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where—as with Mr. DiFelice—the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participant's malady. To the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory.

The second perverse effect is that, at the same time as ERISA makes it inordinately difficult to bring an injunction to enforce a participant's rights, it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see Pilot Life*, 481 U.S. at 54-56, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

In sum, ERISA's remedial scheme gives HMOs every incentive to act in their own and not in their beneficiaries best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess, a confounding result for a statute whose original purpose was to protect employees.

II.

A.

Given that ERISA's remedial scheme often provides no remedies, litigants have gone to great lengths to identify state causes of action that are not preempted by ERISA, and courts have generally been sympathetic to their efforts even when ultimately finding their claims preempted. For example, in *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997), a clearly frustrated court inveighed:

> Under traditional notions of justice, the harms alleged—if true—should entitle [plaintiff] to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.
>
> Nevertheless, this Court had no choice but to pluck [plaintiff's] case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.

Id. at 52-53.

It is no exaggeration to say that the federal courts have struggled mightily to maintain fidelity to ERISA's expansive "relates to" preemption clause while avoiding the wholesale foreclosure of participants' causes of action against their HMOs. But our search for a middle ground has proved to be a judicial snipe hunt, and we are no closer to success today than we were a decade ago. This Court's own decisions illustrate the quagmire in which courts find themselves. In *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), a participant sued his HMO alleging medical malpractice, a state-law tort, and the HMO argued that the claim was preempted by ERISA. We held that the claim was not preempted, reasoning that ERISA draws a distinction between actions challenging the *quality* of care provided and those claiming that the HMO provided an inadequate *quantity* of benefits under its plan. As we explained, actions challenging the *quantity* of benefits received are actions that could be brought under ERISA § 502(a)(1)(B) to "recover benefits due . . . under the terms of the plan," and any state law duplicating that remedy is preempted by ERISA § 514(a). Regulation of *quality* of care, conversely, was found to be "a field traditionally occupied by state regulation," *id.* at 357, and we did not find "anything in the legislative history, structure, or purpose of ERISA suggest[ing] that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice." *Id.*

We further explicated this quantity-quality distinction in *In re U.S. Healthcare*, 193 F.3d 151 (3d Cir. 1999), which concerned, *inter alia*, a plan participant's claim that her HMO was negligent in adopting a policy of presumptively discharging newborn infants within 24 hours. We "recognize[d] that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear," *id.* at 162, and explained that the

line-drawing difficulty arises in part "because the same HMO may have assumed both the role as a plan administrator and the separate role as a provider of medical services." *Id.* The policy of discharging newborns after 24 hours was, however, determined to be a function of the "role as provider of medical services" because it was an "essentially medical determination of the appropriate level of care . . ., not a claim that a certain benefit was requested and denied." *Id.* at 162-63. We therefore held that the plan participant's claim "fit[ ] squarely within the class of claims that we identified in *Dukes* as involving the quality of care" and was not preempted. *Id.* at 163.

Finally, in our most recent and important ERISA preemption decision, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), harm was allegedly caused by an HMO's delay in approving a procedure to be performed by off-network physicians. There was no question whether the treatment itself was covered—the issue was merely one of eligibility, namely whether an off-network physician could perform the procedure. We took note of the Supreme Court's recent decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), where the Court distinguished between an HMO's eligibility decisions and treatment decisions. Although *Pegram* directly concerned fiduciary duty rather than preemption, we held that its eligibility-treatment dichotomy was equally applicable in the preemption context; indeed, we considered it another way of viewing the quantity-quality distinction. We concluded that an eligibility decision is an administrative decision, and that any state-law action challenging it is preempted because a participant could instead bring suit under ERISA § 502(a)(1)(B) "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan." Conversely, a treatment decision is a medical decision that requires no interpretation of the plan

itself, and it is not preempted by ERISA since § 502(a)(1)(B) offers a plaintiff no avenue of relief.

B.

I believe that *Dukes*, *In re U.S. Healthcare*, and *Pryzbowski* were all rightly decided, and that our opinion today reaches the correct conclusion based on those precedents. I write separately, however, to make clear my concern that the opinion masks extraordinary subtleties and complexities of this area of the law that cry out for clarification by the Congress, or, failing that, by the Supreme Court. In fact, I believe that the fundamental distinction upon which federal caselaw currently relies—between quantity and quality decisions, or between eligibility and treatment decisions—is untenable, and that the blurring is becoming more severe, not less. To the extent we insist on categorizing every HMO decision as *either* an eligibility *or* a treatment decision, we contort ourselves into parsing terms that are conceptually indistinguishable, and we fail to come to terms with the realities of modern health coverage.

This problem is evident even among relatively "easy" cases. *Pryzbowski* is perhaps one of the clearest-cut examples of an eligibility decision, for the HMO's only action was designing its plan to utilize network doctors, a clear matter of plan administration. Conversely, when one thinks of "treatment" or "medical" decisions, one envisions a physician and an examination table, a world seemingly far removed from the HMO's administrative offices. Yet even in *Pryzbowski*, it takes little creativity to recast the "administrative" matter of plan design as a "treatment" or "medical" decision, for the HMO implicitly determined that requiring plan participants to see network physicians would not expose them to any undue health risks. It is impossible to characterize that decision as anything other than partially medical, for it directly affected participants' health. Indeed, the delay occasioned by

the HMO's so-called "administrative decision" quite literally caused Ms. Pryzbowski's condition seriously to worsen.

The Supreme Court itself recognized this false dichotomy problem in *Pegram*, where it observed that many (and possibly most) HMO decisions contain elements of both eligibility and treatment considerations:

> [A] great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment.

530 U.S. at 228-29.

Some courts have attempted to explain away the evident problems in the "eligibility versus treatment" dichotomy by holding that only HMOs which employ their own physicians can make medical decisions. *See, e.g., Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 163 F.Supp. 2d 227 (S.D.N.Y. 2001). Such courts suggest that HMOs which do not directly employ physicians cannot engage in "mixed" decisions because they do not actually treat patients. The Supreme Court itself has cast doubt upon this explanation, stating that decisions are considered "mixed" "not merely because . . . treatment and eligibility are made by the same person, the treating physician." *Pegram*, 530 U.S. at 228. But

this distinction is logically tenuous even absent that precedent, for an HMO that employs no physicians must nevertheless review the independent physicians' recommendations to determine whether they comport with the health plan's requirements.

The case at bar makes evident the impossibility that any such simple rule can adequately reflect the Byzantine complexities of modern-day health care. AETNA's policy explicitly equated its coverage (i.e., eligibility) on an assessment of medical necessity. But the medical necessity clause, which attempts to convert medical decisions into eligibility decisions, compounds the problem I address herein. Indeed, Aetna denied coverage even though Dr. Picariello insisted the specialized tracheostomy tube was critical to DiFelice's health. Tracheotomy is an extremely serious procedure, and the tracheostomy tube, whose uses are described in the margin, is an integral part of the procedure.[1] As two prominent medical school professors explain, tracheotomy "is associated with multiple and potentially life-threatening complications even under elective conditions." Eugene N. Myers and Ricardo L. Carrau, *Early Complications of Tracheotomy: Incidence and Management*, 12 Clinics in Chest Medicine No. 3 at 589 (September 1991). Indeed, "[e]ven with the use of optimal surgical techniques, complications of tracheotomy may occur during the procedure, in the immediate postoperative period, or long after the surgery." Eugene N. Myers and Sylvan E. Stool, *Complications of Tracheotomy*,

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[1] The purposes of a tracheotomy tube are: (1) to provide secure continuation of the airway through the passage of the soft tissues of the neck; (2) to offer a possibility of artificial pressure ventilation if needed; and (3) to seal the trachea to prevent aspiration of material above the tube or in the hypopharynx. *See* Carl-Eric Lindholm, *Choice of Tracheostomy Tube*, Tracheotomy 125 (Churchill Livingstone 1985).

Tracheotomy 147 (Churchill Livingstone 1985). They counsel that "[t]he best means of preventing complications whenever they occur [ ] are paying meticulous attention to detail in the performance of the surgery and performing the tracheotomy as soon as it becomes obvious that the procedure is necessary." *Id.*

This assessment is borne out by the history of DiFelice's condition. In March of 2001, DiFelice was diagnosed with sleep and upper airway obstruction. His otolaryngologist, Dr. Michael Picariello, attempted several unsuccessful treatments before determining that DiFelice needed a tracheostomy tube. Dr. Picariello surgically placed a tracheostomy tube in July of 2001, but it continually extubated from DiFelice's neck. It was only then that Dr. Picariello determined that DiFelice needed a specially-designed tube to remedy a potentially life-threatening condition.

Aetna, however, overruled Dr. Picariello's expert medical judgment and determined that the tube was in fact not medically necessary, leaving DiFelice with the option of bringing an injunctive suit under ERISA § 502, paying out-of-pocket for the specially-designed tube, or receiving a second standard-shaped tube that Aetna agreed to cover. He opted for the covered tube, but after it was placed, he developed a serious and progressive soft tissue and bone infection that caused him to be admitted to Chester County hospital in October of 2001, following which he was referred to the Hospital at the University of Pennsylvania. There, doctors removed "significant portions" of his bone and tissue to treat the infection, and his pectoral muscle was surgically reconfigured.

Aetna claims that its decision was not medical merely because it was made with an eye to plan language. To me this makes no sense, for Aetna made precisely the same individualized determination of medical necessity as Dr. Picariello. The fact that Aetna is an HMO and Dr. Picariello

is an independent physician is entirely irrelevant to the fundamental character of their assessments. My conclusion that Aetna's decision may have been largely medical suggests that perhaps DiFelice's claim *should not* be preempted. Such a result would follow comfortably under *Dukes* and *In re U.S. Healthcare*. I agree with Judge Rendell, however, that Supreme Court precedent compels the conclusion that the proper test is whether a suit is theoretically possible under § 502(a), an approach which leads to preemption under the facts of this case.

Judge Rendell's opinion recognizes that Aetna's decision had a medical component. It declines to characterize it as either eligibility or treatment, and concludes that in such mixed situations, preemption turns on the availability relief under ERISA § 502(a). This resolution at least has the salutary effect of creating a bright-line rule, perhaps the best we can hope for absent intervention from a higher authority that would enable a truly principled jurisprudence. But while this rule is relatively easy to apply, that ease comes at the direct expense of plan participants' welfare. The rule's premise is that HMOs that do not employ their own physicians are solely in the insurance business, that is, they do not provide care and cannot be medically negligent. In the opinion's words, "because there is no allegation that Aetna actually provided the medical care, Aetna's use of medical judgment could only have led to an eligibility, not a treatment, decision." I believe that this statement (with which I do not agree) encapsulates precisely why ERISA's failure to change with the times has rendered it incapable of protecting employees, and why Congress must act to prevent further injustice.

C.

As discussed above, existing Supreme Court precedent holds that ERISA disallows extracontractual damages even in instances of bad faith, an interpretation that gives safe harbor

to HMOs that deny claims while also destroying any possibility of participants bringing § 502 actions under contingency fee arrangements. The result is that, in many cases, participants must take HMOs' decisions as law—for example, when Aetna's utilization review board denied coverage for DiFelice's specialized tracheostomy tube, he faced the decision whether to pay for the specialized tube out-of-pocket, whereas appealing the HMO's decision was simply impractical in the face of a medical emergency. In such cases, the critical insight is that the HMO *de facto* determines a patient's *actual treatment* along with his eligibility for benefits, for it will be a relatively rare person who is able to pay for invasive procedures out-of-pocket.

Because ERISA creates a system in which an HMO's benefit determination frequently determines the actual treatment a participant receives, it follows directly that HMOs determine quality of care—and make treatment decisions—regardless of whether they actually employ physicians. Put differently, the root of courts' ERISA preemption nightmare is that ERISA forces them to distinguish between eligibility and treatment decisions while providing a remedial structure that makes the two virtually synonymous. For participants, the torment is still greater: ERISA *de facto* places the HMO in control of the treatment a participant receives, yet it preempts any state-law medical malpractice claim against that HMO and provides that the participant can recover no compensatory, punitive, or wrongful-death damages regardless of its malfeasance.

This situation has arisen because ERISA has failed to evolve to accommodate the rise of HMOs, which did not even exist when ERISA was enacted in 1974. Back then, fee-for-service insurers dominated the health care industry. *See Pegram*, 530 U.S. at 218; *see also* Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue"*, 30 U Mich. J. L. Ref. 147, 171 (1996). Insurers had

little role in a person's treatment decisions; instead, a participant would visit a doctor or hospital, receive treatment, and the doctor or hospital would bill the insurer. If an insurer refused to pay, the participant could bring suit under ERISA § 502(a) to recover benefits due under the terms of the plan. This was the role Congress envisioned for § 502, and it worked well, for any disagreement with an insurer would occur only after the participant's medical crisis had abated, and in some ways the system created an incentive to provide too much care rather than too little.

Times have changed. Today, approximately 75% of insured American workers receive their heath care through some type of "managed care" plan, a designation which includes HMOs. *See* Andy Miller, *Managed Care Savings Noted*, Atlanta J. & Const., June 5, 1997, at E3. One hallmark of managed care systems is the utilization review board, which approves or denies coverage for a procedure before the procedure actually takes place. Although a participant may appeal a utilization review board's decision, the prior-approval system is thought to reduce costs to HMOs because participants are likely to choose an inferior (but approved) procedure over a superior procedure for which they might ultimately pay out-of-pocket following an unsuccessful appeal. ERISA is often ill-equipped to deal with the phenomenon of the utilization review board, for the lack of remedies available under § 502, as discussed above, actively encourages HMOs to deny claims. Because these denials now take place before the treatment itself, the effect is a systematic deterioration in the quality of treatment participants receive, all oxymoronically occasioned by a statute "designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw*, 463 U.S. at 90.

What is to be done? Not much, absent intervention by Congress or the Supreme Court, for lower courts are bound to follow precedents that lead inexorably to the "availability

of § 502 relief" preemption test set forth by the majority opinion in this case. However, several promising avenues exist. One is suggested by the Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong., 1st Sess. (1999), which passed the House but was watered down in the Senate. *See Langbein & Wolk*, Pension and Employee Benefit Law at 561-62. That Act would have amended ERISA § 514 by adding a new subsection (e) providing that ERISA shall not:

> be construed to invalidate, impair, or supercede any cause of action brought by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrong death against any person—
>
> (i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health [plan], or
>
> (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

The Act would have disallowed punitive damages when the cause of action relates to an "externally appealable decision." It set up such external appeal procedures for denials of benefit claims based on decisions that "the item or service is not medically necessary or appropriate or is investigational or experimental" or "in which the decision as to whether a benefit is covered involves a medical judgment."

Put more concretely, had the Act become law, Aetna would now face possible compensatory damages but not punitive damages, and its determination of medical necessity would be externally appealable. Although the Act passed the House, it did not survive in the Senate, which passed a version of health care reform containing no right to sue. *See* H.R. 2990, 106th Cong., 1st Sess. (1999). As suggested, the

legislation approved by the House is one approach. There are doubtless others.

Even if Congress refuses to act, however, the Supreme Court, in its interpretive capacity, is capable of effecting salutary change in many ways. The Court has no crystal ball, and twenty years ago it could not have foreseen the radical changes that have overtaken the health care system, and the difficulties that its preemption decisions would create. The time might be right to reconsider the string of holdings, epitomized by *Russell* and *Mertens*, that rule out the possibility of recovering compensatory damages under ERISA § 503(a)(3). *See generally* John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in* Russell, Mertens, *and* Great-West, Yale Law School Center for Law, Economics, and Public Policy, Research Paper No. 269, available online at *www.ssrn.com*. Professor Langbein persuasively argues: (1) that the Supreme Court erred in interpreting ERISA's language providing for "other appropriate equitable relief" to mean only relief that was traditionally available in courts of equity; and (2) that the better view is that Congress intended "to remedy ERISA wrongs of the sort commonly remedied under trust law," and a core principal of trust law, the "make-whole standard," attempts to "restore[ ] the victim to the position that he or she would have had had there been no breach of trust."

That is precisely what compensatory damages do, and there is no reason to suspect that Congress intended to base ERISA on the law of trusts while omitting the predicate law's core remedy. I note that I am not alone among federal judges in urging the Supreme Court to reconsider what has become a significant barrier to justice and the realization of Congressional intent. *See, e.g.*, *Cicio v. Does*, 321 F.3d 83, 107 (2d Cir. 2003) (Calabresi, J., dissenting) ("[I]t is not too late for the Supreme Court to retrace its Trail of Error and start over from the beginning, or for Congress to wipe the

slate clean."). *Cf. Corcoran v. United Healthcare*, 965 F.2d 1321, 1336 (5th Cir. 1992) ("The characterization of equitable relief as encompassing damages necessary to make the plaintiff whole may well be consistent with the trust law principles that were incorporated into ERISA and which guide its interpretation.").

Another possibility for the Supreme Court, especially given its recent trend toward looking beyond the text of § 514(a) to determine ERISA's preemptive scope, is to reexamine Congress's intent (or lack thereof) with respect to preempting welfare benefit plans. Many scholars have noted that Congress did not carefully consider the scope of preemption when it drafted ERISA. *See, e.g.*, Fick, *The Last Article about the Language of ERISA Preemption?*, 33 Harv. J. on Legis. 35, 53 (1996). The House bill would have preempted state laws that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities of persons acting on behalf of" ERISA-covered plans, and state laws that "relate to" funding and benefits-vesting provisions of pension plans. H.R. 2, 93d Cong., 1st Sess. (1973), 120 Cong. Rec. 4742 (1974). The Senate version, on the other hand, would have preempted state laws that "relate to the subject matters regulated by this Act." S. 4200, 93d Cong., 1st Sess. (1973), 120 Cong. Rec. 5002 (1974).

In the final joint conference, the Committee adopted the present language, but made it available to the full Congress only ten days before the bill was enacted, and said little about the change. *See Metropolitan Life Ins. Co.*, 471 U.S. at 745 n.23. There is scant reason to believe that the resulting language was fully considered by the entire deliberative body; indeed, those who paid attention to the issue opined that § 514(a) was provisional. Section 3022 mandated the creation of a Joint Pension Task Force to study the practical effect and desirability of preemption, and Senator Jacob Javits, a sponsor of the legislation, said that "the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits). Unfortunately, the Task Force never came into existence, and no further regulation was forthcoming.

The evidence suggests that Congress did not carefully consider whether the scope of preemption should reflect the different degrees of federal regulation of pension plans and welfare benefit plans. *See* Fisk, *The Last Article about the Language of ERISA Preemption?*, 33 Harv. J. on Legis. at 56. In my view, section 514(a)'s broad preemptive scope is sensible with regard to pension plans, for federal law fully displaces state law and provides vesting, requirements, minimum funding requirements, and a raft of other employee safeguards. However, to me, it makes much less sense with respect to welfare plans. As discussed *supra*, Congress exempted welfare benefit plans from most of ERISA's substantive regulations, such as its vesting and minimum funding requirements.

As I see it, it is unlikely that Congress intentionally created this so-called "regulatory vacuum," in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute. The more likely explanation is that Congress merely intended to create minimum safeguards to protect the financial integrity of welfare benefit plans while stopping short of federalizing the entire remedial regime, especially in light of what was a workable state-law remedial system. Congress's failure to distinguish explicitly between pension and welfare benefit plans in § 514(a) is understandable, for, as explained above, the managed care plans that wreak havoc with § 514(a) as it relates to welfare benefit plans did not exist when ERISA was enacted. There is no evidence that Congress envisioned the current situation.

Taking note of Congress's understandable lack of clairvoyance, the Supreme Court might embrace pragmatism and

limit § 514(a)'s preemptive scope regarding welfare benefit plans. Although the distinction would find little support in the text of ERISA itself, Justices Scalia and Ginsburg recently admitted in a concurrence that:

> [A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. The statutory text provides an illusory test, unless the Court is willing to decree a degree of preemption that no sensible person could have intended—which it is not.

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc., 519 U.S. at 335-36 (1997) (internal citation omitted). Absent textual guidance or meaningful legislative history, there is little to prevent a pragmatic solution to a problem Congress has not confronted.

No doubt there are other possible solutions. The vital thing, however, is that either Congress or the Court act quickly, because the current situation is plainly untenable. Lower courts are routinely forced to dismiss entirely justified complaints by plan participants who have been grievously injured by HMOs and plan sponsors, all because of ERISA, the very purpose of which was to safeguard those very participants. Our dockets grow increasingly crowded with cases where participants offer myriad varieties of artful pleadings in their desperate attempts to circumvent ERISA's procrustean reach, and our caselaw grows massively inconsistent due to the sheer complexities of the subject and lack of any meaningful guidance. There must be a better way.

The Clerk of Court is directed to send a copy of this opinion (with attention directed to the concurrence) to the Solicitor of the Department of Labor; the Chair, Ranking Member, Chief Majority Counsel, and Minority Counsel of the Senate Committee on Health, Education, Labor, and Pensions; and the Chair, Ranking Member, Chief Majority

Counsel, and Minority Counsel of the House Committee on Education and the Workforce.

AMBRO, Circuit Judge, *concurring*:

Judge Rendell's opinion is well-crafted, and I join it. In many cases, however, the result underwhelms. Thus, like Judge Becker, I implore for a better way to make these kinds of decisions.

Congress in 1974 passed "a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.* 463 U.S. 85, 90 (1983). That statute—the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*—made policy compromises in order to combat exponentially rising health care costs in a melange of state tort laws assessing negligence after-the-fact. *See generally* Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 Yale L.J. 1297 (1994). Among the newer forms of managing the providing of healthcare services was to "'prospectively and concurrently assess the appropriateness of care. . . .'" *Id.* at 1302 (quoting Elizabeth W. Hoy *et al.*, *Change and Growth in Managed Care*, HEALTH AFF., Winter 1991, at 27).

Instead of healthcare insurers reimbursing insureds for already-given medical care, health maintenance organizations ("HMOs") were created where, upon "receipt of a fixed fee for each patient enrolled under the terms of a contract [,] . . . specified health care [is provided] if needed." *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000). Physicians contract with HMOs to provide services to patients in the HMO for set fees. HMOs, via a health plan purchased by patients' employers, set "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services. . . ." *Id.* at 223. The bottom line—non-routine medical services are provided after they are approved.

This system, simple in concept, has sisyphean frustration in application. At the forefront is preemption. To save costs in a tort system where medical decisions by service providers are second-guessed by non-medical persons, ERISA preempts state law that conflicts with ERISA, 29 U.S.C. § 1144(a), and is a "cause of action within the scope of the civil enforcement provisions of [ERISA] § 502(a) [29 U.S.C. § 1132(a)]." *Cicio v. Does*, 321 F.3d 83, 94 (2d Cir. 2003) (quoting from *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)). Included within this subsection is any civil action brought "by a [plan] participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . ." 29 U.S.C. § 1132(a)(1)(B). Stated colloquially, ERISA "federalizes" most employee benefit plan remedies.

Judges Rendell and Becker in this case, and Judge Calabresi in his partial dissent in *Cicio*, 32 F.3d at 106 *et seq.*, point out poignantly the so-often unsatisfying constructs we use to cipher meaning when cultures of cost containment and tort responsibility clash over preemption. "The litigants in these cases spar over the extent to which a lay financing entity [the HMO] has appropriated to itself distinctly *medical* authority by substituting its own expertise for that of the treating physician." Frankel, 103 Yale L.J. at 1303 (emphasis in text). I join the chorus calling for a fresh look from higher authority to promote better the primary Congressional purpose of ERISA—protecting plan participants and their beneficiaries. "At issue is nothing less than the definition of medical decision-making itself," *id.*, and the lives that this affects.

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No. 02-1845

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Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, THE AMERICAN BENEFITS COUNCIL AND THE NATIONAL ASSOCIATION OF MANUFACTURERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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Pursuant to Rule 37.2 of the Rules of this Court, the American Association of Health Plans, Inc. ("AAHP"), the Chamber of Commerce of the United States of America (the "Chamber"), the American Benefits Council (the "Council") and the National Association of Manufacturers (the "NAM") respectfully move for leave to file the attached brief as *amici curiae* in support of Petitioner. Petitioner has consented to the filing of this brief. Its letter of consent has been lodged with the Clerk of the Court. Respondent has declined to consent.

The AAHP is the national association for the managed care community. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. Its membership includes health maintenance organizations, preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*

The Chamber is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

The Council is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The NAM is the nation's largest industrial trade association. The NAM represents 14,000 members (including 10,000 small and mid-sized companies) and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

Amici file this brief because of their interest in preserving the ability of the managed care community to arrange for quality, affordable health care, including prescription drug benefits, on behalf of ERISA-covered health plans. The Fifth Circuit's decision substantially increases the liability of persons that make benefit claims decisions, increasing health plan costs, thereby discouraging employers from providing prescription drug benefits and health plans to their employees.

For the foregoing reasons, AAHP, the Chamber, the Council and the NAM respectfully request that they be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*

The interest of *amici curiae*, AAHP, the Chamber, the Council and the NAM are set forth in the motion accompanying this brief.[1]

[1] Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part and no person or entity other than *amici* contributed monetarily to the preparation and submission of this brief.

STATEMENT OF THE CASE

The *amici* incorporate the Statement of the Case in the Petition for Writ of Certiorari and briefly summarize the portions of the opinion of the United States Court of Appeals for the Fifth Circuit (App. 1a-29a) (*Davila*) relevant to their arguments.

Juan Davila's primary care physician prescribed the anti-inflammatory medication Vioxx for treatment of Davila's arthritis. However, the prescription drug formulary established as part of the health plan maintained by Davila's employer, Monitronics International, Inc., required that Davila obtain pre-certification prior to coverage of Vioxx.[2] The formulary provided coverage for similar, but less costly, medication without pre-certification.[3]

Aetna denied Davila's claim for Vioxx. Aetna provided notice that Davila's physician had not sought pre-certification, but that the plan would cover Vioxx if Davila's physician indicated that the less costly drug was contraindicated. The letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to Davila. App. 80a-81a.

[2] The cost of prescription drugs has skyrocketed over the last several years. In 2001, prescription drug costs climbed 17 percent, contributing to a 13 percent increase in total health plan costs. *See* Howard Weiss, Prescription Drug Formularies: Ensuring Access to Safe and Effective Medications, HEALTHPLAN, November/December 2002 at 52. The vast majority of health plans make drug benefits available through a formulary, which is one means of controlling drug benefit costs. A formulary lists drugs that a plan will cover as a benefit. A formulary typically provides different co-payment amounts for different groups of covered drugs and excludes some drugs from coverage. Health plans commonly require pre-certification for certain drugs included in the formulary. At least thirty-nine states impose some formulary restrictions as part of their Medicaid programs. *See* Renee Schwalberg, *et al.*, Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights at 6-7 (2001).

[3] In 2000, 96% of private sector employees with employer-sponsored health coverage were enrolled in plans that included pre-certification or similar utilization review requirements. *See* Bureau of Labor Statistics, National Compensation Survey: Employee Benefits in Private Industry in the United States at 10-11, 29 (2003).

Under its contract with Monitronics, Aetna made final decisions with respect to claims for benefits under the plan. App. 102a.[4] However, Aetna did not provide medical services to Davila, nor did Aetna supervise or control the actions of treating physicians made available under the plan's preferred provider network. App. 98a.

Aetna's claims decision was comprehensively regulated by ERISA. Aetna was subject to ERISA's mandated claims procedure, which imposes notice and appeals requirements on group health plans. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. In making claims decisions, Aetna served as a fiduciary of the Monitronics plan. 29 U.S.C. § 1002(21)(A); *Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *Pacificare Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994). As a fiduciary, Aetna was subject to ERISA's fiduciary duties of prudence and loyalty, as well as its prohibition against fiduciary self-dealing and kickbacks. 29 U.S.C. §§ 1104, 1106(b). ERISA's detailed remedial scheme provided plan participants—such as Davila—with a remedy for a denied benefit claim or a breach of fiduciary duty. 29 U.S.C. § 1132(a)(1)(B), (a)(2) & (a)(3).

[4] While policies issued by HMOs and insurance companies themselves do not constitute ERISA plans, such policies commonly set forth all or part of the terms of an employee benefit plan, including plan benefits. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). When disputes arise over policy terms, however, plan participants must bring claims under ERISA to enforce the terms of the plan. *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997).

Following notice of Aetna's claims decision, Davila failed to pursue his administrative remedy to appeal the decision as provided under ERISA section 503, and as set forth in Aetna's denial letter to him. Davila also failed to pursue review by an independent review organization as set forth in Aetna's letter. And Davila chose not to pursue his judicial remedy to sue for benefits under ERISA section 502(a)(1)(B). Instead, Davila later sought redress for Aetna's claims decision in Texas state court asserting that Aetna failed to exercise "ordinary care"—the standard negligence test—under the Texas Health Care Liability Act. App. at 69a.

Aetna removed Davila's action to the U.S. District Court for the Northern District of Texas, asserting that the claim was completely preempted by ERISA and removable under *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). The district court agreed, concluding that "distilled to its essence" Davila's claim "concerns the administration of benefits under the plan." App. at 34a.

The Fifth Circuit reversed. The court applied a self-described "narrow" test for complete preemption, concluding that ERISA section 502 preempts only those state law claims that "duplicate[]" a cause of action provided under ERISA section 502. *Id.* at 9a. Applying this test, the court found that Davila's tort claim did not encroach on ERISA's remedies since it did not duplicate the equitable claims authorized by section 502(a)(3), the fiduciary duty claims authorized by section 502(a)(2) or the contract claims authorized by section 502(a)(1)(B). *Id.* at 12a-20a.

The Fifth Circuit's test for complete preemption looked at whether the state law cause of action and form of relief sought by Davila were available under ERISA. Because tort claims for money damages are not available under ERISA, the court found that Davila's claims were not completely preempted.

REASONS FOR GRANTING THE PETITION

The Fifth Circuit's *Davila* decision threatens the foundation on which ERISA was built. Congress constructed ERISA taking into account the fact that employers voluntarily offer benefit programs to their employees and that the inherent costs of state by state regulation must be limited. In order to encourage employers to offer benefit plans, Congress included ERISA section 514, an express preemption provision, to foster uniform and lower cost regulation of multi-state benefit plans. Congress also adopted a detailed, but exclusive, remedy scheme under ERISA section 502, to ensure that plans were not subject to a costly patchwork of conflicting and open-ended state law remedies.

The Fifth Circuit mistakenly relies on dicta in this Court's *Pegram* decision to depart from an unbroken string of Supreme Court decisions holding that ERISA's remedies are exclusive. *Davila* leaves employers and labor unions who sponsor plans, and the insurers and third party administrators who act on their behalf, exposed to suits for compensatory and punitive damages under varying state laws for routine health plan claims decisions. All health plans will be affected—both insured and self-insured.

Davila will result in a patchwork of remedies that will expand liability and increase health plan costs. Routine plan provisions, such as pre-certification and drug formularies, will be compromised. Employers will be forced to take measures to restrict or eliminate prescription drug and other benefits to limit cost increases. Consumers and plan participants will pay the ultimate price—facing higher co-payments, deductibles and premiums, while being subject to restricted benefits and drug selection.

ERISA's remedy scheme reflects a careful balancing of interests that Congress made after a decade of study. Allowing states to supplement ERISA's remedy scheme with

tort claims with potentially unlimited money damages against claims administrators eviscerates the policy choices Congress is best suited to make.

I. THE COURT SHOULD GRANT THE PETITION TO CLARIFY ITS DECISION IN *PEGRAM V. HERDRICH* AND RESTORE UNIFORMITY AND EXCLUSIVITY TO ERISA'S REMEDY SCHEME FOR BENEFIT DISPUTES.

A. Uniformity in administration and remedies lowers administrative expenses and litigation costs and fosters America's voluntary employee benefits system.

Over 130 million Americans participate in group health plans governed by ERISA, all of which are voluntarily sponsored by employers and labor unions. *See "Small Business Health Fairness Act": Hearing on H.R. 660 Before the Subcom. on Employer-Employee Rel. of the House Comm. on Educ. & the Workforce*, 108th Cong. (Mar. 13, 2003) (statement of Ann L. Combs, Ass't Sec'y for Employee Benefits Sec., U.S. Dep't of Labor). ERISA reflects "competing congressional purposes, such as Congress's desire to offer employees enhanced protection for their benefits . . . and its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

"One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)). Of course, providing for uniformity lowers plan administrative expenses and legal costs and encourages employers to voluntarily

sponsor group health plans. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Id.*

Providing an exclusive remedy for claims decisions is essential to fulfilling Congress's goal of controlling employer costs by promoting nationally uniform plan administration. This Court has made clear that was Congress's intent:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

The Court has never deviated from its conviction that ERISA's remedies are exclusive. In *Taylor*, 481 U.S. 58, decided on the same day as *Pilot Life*, the Court held that a complaint filed in state court alleging, on its face, only state law causes of action was properly removable to federal court under the doctrine of "complete preemption." The *Taylor* decision rests on the same fundamental conclusion as *Pilot Life*—that ERISA's remedies are so comprehensive that Congress's intent to provide an exclusively federal set of remedies is manifest. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143 (1990) (even without preemption under section 514(a), state law cause of action would be preempted because it conflicts with ERISA section 502).

The Court affirmed its view just recently in *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). In *Rush*, the Court found that the Illinois independent review requirement, which it likened to a second medical opinion rather than an arbitration remedy, did not run afoul of ERISA's exclusive remedy scheme since the law "provides no new cause of action under state law and authorizes no new form of ultimate

relief." *Id.* at 379. Thus, an independent reviewer's decision would be enforceable in an action under ERISA section 502, *see Moran v. Rush Prudential*, 230 F.3d 959, 971 (7th Cir. 2000), and "[would] not enlarge the claim beyond the benefits available in any action under section 502(a)." 536 U.S. at 379.

The Fifth Circuit adopted a "narrow" view of the *Taylor* complete preemption doctrine, finding that ERISA section 502 preemption applies only when the state law cause of action *duplicates* one of ERISA's specific remedies. App. at 9a. The decision completely disregards this Court's decisions in *Pilot Life*, *Taylor* and *Ingersoll-Rand*, each of which addressed an underlying state tort claim that did not in any way duplicate any of the remedies in ERISA section 502. Plaintiffs will easily circumvent ERISA's remedies and federal jurisdiction by simply pleading state tort claims and avoiding state contract or equitable claims. The result will be to permit a "new cause of action under state law" providing "a new form of ultimate relief." *Rush*, 536 U.S. at 379. Indeed, that is precisely what happened in this case, with Davila asserting a cause of action for money damages under the Texas Health Care Liability Act, instead of pursuing the administrative and judicial remedies provided under ERISA.[5]

The Fifth Circuit's decision eviscerates Congress's overarching goal of limiting costs by promoting uniformity. *Davila* applies equally to insured and self-insured health plans. It applies to benefits available under a drug formulary, as well as any other plan benefits. If left intact, a fifty-state patchwork scheme of ERISA enforcement will apply to

[5] A number of states have adopted statutes similar to the Texas law, which are intended to provide remedies against HMOs and insurers for benefit claims denials. *See, e.g.*, Ga. Code Ann. §§ 51-1-48, 51-1-49; Me. Rev. Stat. Ann. tit. 24-A, § 4313. Moreover, state common law likely provides a remedy in those states that have not adopted a statutory remedy like the Texas law.

administrative decisions to pay or deny claims for benefits. Faced with different state liability rules, administrators will make conflicting decisions because of different remedies—simply depending on where the participant lives. And employer costs will skyrocket as plans absorb increased litigation expenses and pay for more expensive drugs and other benefits for which coverage was not contracted. Consumers will pay the ultimate price—co-payments and deductibles will increase and plan benefits will decrease or be eliminated—all due to expanding liability.

Clearly, *Davila's* narrow view of ERISA section 502 "stands as an obstacle to the accomplishment or the full purposes and objectives of Congress." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (ERISA supersedes saved state insurance law applying traditional preemption principles). This Court should grant the petition and confirm that ERISA completely preempts state law remedies that supplement the remedies that ERISA provides for conduct that ERISA regulates.

B. The *Davila* decision mistakenly relies on the Court's "mixed eligibility" discussion in *Pegram* to deviate from the appropriate ERISA preemption analysis.

Prior to this Court's decision in *Pegram*, the circuit courts uniformly recognized that ERISA sections 514 and 502 preempt state law claims, whether tort or contract, that challenge an ERISA plan's claims decision, including claims determinations based on plan provisions that limit coverage to medically necessary treatments or condition coverage on pre-certification. *E.g.*, *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999); *Danca v. Private Health Care Sys.*, 185 F.3d 1 (1st Cir. 1999); *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996); *Cannon v. Group Health Servs. of Oklahoma*, 77 F.3d 1270 (10th Cir. 1996); *Tolton v.*

American Biodyne, 48 F.3d 937 (6th Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). The courts reached this conclusion based on the administrative nature of the claims decisions, recognizing that such decisions may involve medical judgment.

The Fifth Circuit mistakenly relied on *Pegram* for its conclusion that ERISA section 502 does not preempt Davila's tort claim. The Second Circuit and Eleventh Circuit have aligned themselves with the Fifth Circuit. *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003); *Land v. Cigna Healthcare of Florida*, ___ F.3d ___, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003). But the Fourth Circuit and Third Circuit have rejected the temptation to revisit the teachings of *Pilot Life* in light of *Pegram*. *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001).

The holding in *Pegram* is straightforward: an HMO's treating physician does not act as an ERISA fiduciary when making a medical treatment decision. Not surprisingly, the Court also indicated its understanding that treating physicians who make inappropriate treatment decisions are subject to state malpractice suits. *Id.* at 236. Indeed, that occurred in *Pegram* where the treating physician was found liable for malpractice under Illinois law. *Id.* at 217-18.

Pegram, however, includes dicta which characterizes the physician's decision as a "mixed eligibility decision"—a decision with both eligibility and treatment components—which may be redressed by a suit under state law. This "mixed eligibility decision" discussion has been improperly construed in *Davila*, *Cicio* and *Land* to signal this Court's intent to expose a claims administrator—who is not acting in a direct treatment capacity—to state law claims whenever the claim arguably involves some form of medical judgment.

A closer read of *Pegram* reveals that the key inquiry is whether the person acts as a fiduciary in making the decision that is the subject of the complaint. *Id.* at 224-36. In *Pegram*, the Court judged that Congress did not intend for ERISA's strict duty of loyalty and prohibitions on conflicts of interest to displace state law in regulating physician conduct and compensation arrangements. As such, the treating physician in *Pegram* did not act as an ERISA fiduciary, and was subject to state law. In contrast, Aetna acted purely as a claims administrator and plan fiduciary and was subject to ERISA's regulation and exclusive remedies.

This Court should grant the petition to make clear what seems obvious—the *Pegram* Court was analyzing a treating physician making a *direct treatment decision* with respect to a patient. The Court was not analyzing the action of an ERISA fiduciary acting in an administrative capacity. And the *Pegram* Court had "no occasion" to address the scope of preemption under ERISA sections 514 and 502 with respect to such claims decisions even when such decisions are alleged to involve some medical judgment. *Id.* at 229, n.9. But *Davila* reflects the Fifth Circuit's judgment that *Pegram* overrules *Pilot Life* and *Taylor*. Instead, the Fifth Circuit should have followed the settled principle that the Court does "not normally overturn, or so dramatically limit, earlier authority *sub silentio*." *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 3 (2000).

II. THE DECISION TO MODIFY ERISA'S EXCLUSIVE REMEDY SCHEME IS PROPERLY LEFT IN THE HANDS OF CONGRESS, WHICH HAS ACTIVELY CONSIDERED THE MATTER FOR MORE THAN A DECADE AND, TO DATE, HAS CHOSEN NOT TO ACT.

The Court has repeatedly emphasized that ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private

employee benefit system." *Great-West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 2004 (2002) (quoting *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 251 (1993) and *Nachman v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 361 (1980)). The Court therefore has been "reluctant to tamper with an enforcement scheme crafted with such evident care. . . ." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

The Court's respect for congressional policy choices is evident in its determination that ERISA's remedies are exclusive:

> [T]he detailed provisions of § 502 set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54.

Congress fully understands that ERISA's remedies are exclusive. Informed by *Pilot Life*, for more than a decade Congress has debated whether to lift ERISA preemption to permit state law suits, add a new damages remedy directly to ERISA, or leave existing remedies intact.[6] But unlike the decade of study that led to ERISA, no congressional consensus has emerged.

[6] Early consideration occurred in 1991 when Representative Berman (D-CA) and Senator Metzenbaum (D-OH) sought to amend ERISA section 514 to allow state law claims against insurers to address the Court's decision in *Pilot Life*. *See* Health Insurance Claims Fairness Act of 1992, H.R. 1602, 102d Cong. (1991); S. 794, 102d Cong. (1991).

Recent legislative consideration occurred from 1998 through 2001 when the House of Representatives and the Senate passed a number of Patients' Bill of Rights acts with very different remedy provisions.[7] For example, the most recent Senate-passed measure, S. 1052, endorsed a complex scheme of state and federal remedies. Under the Senate approach, ERISA would not preempt state lawsuits where a claims decision involved some form of medical judgment. *See* S. 1052, § 402(b) (amending ERISA section 514). In addition, a new federal remedy under ERISA would be established for claims denials that did not involve medical judgments with unlimited compensatory damages and a $5 million limit on punitive ("statutory") damages. *See* S. 1052, § 402(a) (amending ERISA section 502). In contrast, the most recent House-passed measure adopted added exclusively federal remedies, with limits on both compensatory and punitive damages, and affirmed that state law claims involving claims determinations are preempted. *See* H.R. 2563, § 402(a).

This past year, Congress has chosen not to act on similar legislation. But this too reflects a policy choice—a decision not to add costly new damages remedies against ERISA health plans at a time of spiraling health care premiums and costs. *See* Barbara Martinez, *Health Benefits Post Highest Gain Since '90*, WALL ST. J., Dec. 9, 2002, at A6 (health care costs expected to rise by 14% in 2003).

This Court should grant the petition so that the contours of ERISA's remedy scheme remains entrusted to Congress. The Court has recognized many times that courts are ill-suited to make the types of sweeping policy decisions Congress must

[7] *See* Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. (2001); Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001); Bipartisan Consensus Managed Care Improvement Act, H.R. 2990, 106th Cong. (1999); Patients' Bill of Rights Act, S. 1344, 106th Cong. (1999); Patient Protection Act, H.R. 4250, 105th Cong. (1998).

routinely make. *See, e.g., Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 195 (1978). Indeed, the *Pegram* decision itself recognized that Congress alone must expand or retract the reach of ERISA. *Pegram*, 530 U.S. at 234. Instead of following this teaching of *Pegram*, the lower courts in *Davila*, as well as *Cicio* and *Land*, have grasped at the Court's dicta in *Pegram* and rushed to make the types of policy decisions that Congress alone is suited to make.

CONCLUSION

The petition for writ of certiorari should be granted.

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IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, *et al.*,

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On Writs Of Certiorari
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7/11/01	Private civil federal case docketed. NOA filed by Appellant Juan Davila. [01-10905] (trm) [01-10905]
8/27/01	Appellant's Brief filed by Appellant Juan Davila. Copies of brief: 7 # of pages: 60. Word count: 13,958 Disk Provided [Y/N]: y Date of COS: 8/27/01 Sufficient [Y/N]: y [01-10905] A/Pet's Brief ddl satisfied. E/Res's Brief due on 9/26/01 for Aetna US Hlthcare N, for Aetna US Hlthcare. (dsb) [01-10905]
8/27/01	Record excerpts filed by Appellant Juan Davila # of copies: 4 Sufficient [Y/N]: y. [01-10905] (dsb) [01-10905]
10/26/01	Appellee's Brief filed by Appellee Aetna US Hlthcare, Appellee Aetna US Hlthcare N. Copies of Brief: 7 # of pages: 49. Word count: 11,628 Disk Provided [Y/N]: y Date of COS: 10/25/01 Sufficient [Y/N]: y. [01-10905] E/Res's Brief ddl satisfied. Reply Brief due on 11/9/01 for Juan Davila. (dsb) [01-10905]
11/14/01	Reply brief filed by Appellant Juan Davila. Copies of Brief: 7 # of pages: 29. Disk Provided [Y/N]: y Date of COS: 11/9/01 Sufficient [Y/N]: y. [01-10905] Reply Brief ddl satisfied. (jaa) [01-10905]
5/6/02	Oral argument heard. Case argued by George Parker Young for Appellant Robert Roark; Robert Roark, on behalf of the Estate of Gwen Roark in 01-10831, Robert N Eccles for Appel-

lee Humana HMO Texas Inc, Appellee Humana Health Plan, Appellee Humana Inc in 01-10831, George Parker Young for Appellant-Cross-Appellee Ruby R Calad in 01-10891, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Robert N Eccles for Appellee Cigna Healthcare TX in 01-10891, George Parker Young for Appellant Juan Davila in 01-10905, John Bruce Shely for Appellee Aetna US Hlthcare of North Texas, Appellee Aetna US Hlthcare in 01-10905, George Parker Young for Appellee Walter Patrick Thorn, Appellant-Cross-Appellee Ruby R Calad in 01-10943, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (pft) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Opinion filed. Issd in T form? Y Issue Mandate due on 10/8/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943 . [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Judgment entered and filed. [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US

Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 for rehearing. # of copies filed: 4 [3829883-1]. Issue Mandate ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 for rehearing en banc. # of copies filed: 20 [3830095-1] Sufficient Rehearing due on 10/11/02 for Aetna US Hlthcare N in 01-10891, for Aetna US Hlthcare in 01-10891, for Aetna US Hlthcare N in 01-10905, for Aetna US Hlthcare in 01-10905, for Aetna US Hlthcare N in 01-10943, for Aetna US Hlthcare in 01-10943. Sufficient [Y/N]: N Missing statement of facts. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/1/02 Petition filed by Appellee Cigna Healthcare TX in 01-10891 for rehearing en banc. # of copies filed: 20 [3831100-1]. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

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01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 [01-10891, 01-10831, 01-10905, 01-10943] Sufficient Rehearing ddl satisfied. (mcs) [01-10831 01-10891 01-10905 01-10943]

10/10/02 Petition filed by Appellant Robert Roark in 01-10831 for rehearing en banc. # of copies filed: 20 [3839307-1]. Submit Rehearing due ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/24/02 Response requested by the Court to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, Response/Opposition due on 11/4/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943. in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, petition for rehearing en banc [3831100-

1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc (3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (ksw) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant Juan Davila in 01-10905, Appellant-Cross-Appellee Ruby R Calad in 01-10943 to petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for

rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N Response/Opposition ddl satisfied in 01-10831, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N in 01-10943. Sufficient [Y/N]: Y. [4006462-1] [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

11/4/02 Response/opposition filed by Appellee Humana Inc in 01-10831, Appellee Humana Health Pln TX in 01-10831, Appellee Humana HMO Texas Inc in 01-10831 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1]

by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y. [4006487-1] [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943. Sufficient [YIN]: Y [4006523-1]. [01-10831, 01-10891, 01-10905, 01-10943]

(mcs) [01-10831 01-10891 01-10905 01-10943]

11/5/02 Response/opposition filed by Appellee Cigna Healthcare TX in 01-10891 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y [4006951-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Aetna US Healthcare Inc and Aetna US Healthcare of North

Texas, Inc's petition for rehearing [3829883-1] in 01-10831, 01-10891, 01-10905, 01-10943, denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas Inc's petition for rehearing en banc [3830095-1] in 01-10831, 01-10891, 01-10905, 01-10943. With poll (Y/N)?: N. Issue Mandate due on 4/22/03 in 01-10831, in 01-10891, in 01-10905, in 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Robert Roark's petition for rehearing en banc [3839307-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943, denying Cigna Healthcare of Texas Incorporated's petition for rehearing en banc [3831100-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]

4/23/03 Mandate issued. Approved BOC Issued (Y/N)?: y [01-10831, 01-10891, 01-10905, 01-10943] Issue Mandate ddl satisfied. (wdc) [01-10831 01-10891 01-10905 01-10943]

Relevant Docket Entries in U.S. District Court for the Northern District of Texas, Case No. 4:00-cv-01855, *Davila v. Aetna U.S. Healthcare Inc.*

Filing Date	#	Docket Text
12/12/2000	1	NOTICE OF REMOVAL; Filing Fee $150.00 Receipt # 35250 (dld) (Entered: 12/13/2000)
12/12/2000	1	DEMAND for jury trial by plaintiff Juan Davila made in state court on 11/9/00 (dld) (Entered: 12/13/2000
12/12/2000	1	ANSWER to Complaint by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT made in state court on 12/01/00 (dld) (Entered: 12/13/2000)
01/25/2001	5	MOTION by plaintiff Juan Davila to remand (8pgs) (fba) (Entered: 01/26/2001)
01/25/2001	6	MEMORANDUM by plaintiff Juan Davila in support of [5-1] motion to remand (15+ pgs) (fba) (Entered: 01/26/2001)
01/25/2001	7	APPENDIX by plaintiff Juan Davila in support of [5-1] motion to remand (15+pgs) (fba) (Entered: 01/26/2001)
02/14/2001	9	RESPONSE and BRIEF by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT in opposition to plaintiff's [5-1] motion to remand (15+pgs) (fba) (Entered: 02/15/2001)

Filing Date	#	Docket Text
02/14/2001	10	APPENDIX by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT in support of [9-1] opposition response (15+pgs] (fba) (Entered: 02/15/2001)
02/28/2001	13	12(B)(6) MOTION with memorandum in support by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT to dismiss for failure to state a claim upon which relief can be granted (6pgs) (fba) (Entered: 02/28/2001)
03/09/2001	14	RESPONSE by plaintiff Juan Davila to [13-1] motion to dismiss for failure to state a claim upon which relief can be granted (15+pgs) (fba) (Entered: 03/09/2001)
03/09/2001	14	REPLY by plaintiff Juan Davila to Aetna's response to plaintiff's [5-1] motion to remand (fba) (Entered: 03/09/2001)
03/09/2001	15	Second APPENDIX by plaintiff Juan Davila in support of [5-1] motion to remand (15+pgs) (fba) (Entered: 03/09/2001)
03/30/2001	19	REPLY IN SUPPORT by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT to response to defendants' [13-1] motion to dismiss for failure to state a claim upon which relief can be granted (15+pgs) (fba) (Entered: 04/02/2001)

Filing Date	#	Docket Text
06/29/2001	25	ORDER denying [5-1] motion to remand, granting [13-1] motion to dismiss for failure to state a claim upon which relief can be granted . . . . Plaintiff's state-law is Dismissed With Prejudice to the refiling of same . . . . SEE ORDER FOR SPECIFICS . . . . (Singed by Terry R. Means) Copies to counsel: 06/29/01 Page(s) 6 (fba) (Entered: 06/29/2001)
06/29/2001	26	FINAL JUDGMENT . . . . Ordered that all claims are hereby Dismissed With Prejudice to their refiling; all costs of court under 28 U.S.C. 1920 shall be borne by Plaintiff. (Signed by Judge Terry R. Means) Copies to counsel: 06/29/01 Page(s): 1 (fba) (Entered: 06/29/2001)
06/29/2001	27	NOTICE OF APPEAL by plaintiff Juan Davila re [25-1] order, [26-1] judgment order; fee due; TO given; no hearing/trl held; cy to judge and all parties (2pgs) (fba) Modified on 07/02/2001)

Filing Date	#	Docket Text
04/25/2003	30	JUDGMENT/MANDATE of USCA #01-10905 as to 27 Notice of Appeal filed by Juan Davila . . . ordered and adjudged that the judgment of the DC is reversed, and the cause is remanded to the DC for further proceedings in accordance with the opinion of this Court. Further ordered that dft-appellees pay to pla-appellant the costs on appeal to be taxed by the Clerk of this Court. Issued as Mandate: 04/23/2003. (csw,) (Entered: 04/25/2003)
05/09/2003	33	FINAL JUDGMENT OF REMAND . . . In accordance with the opinion of the Fifth Circuit Court of Appeals, issued as mandate on April 23, 2003, and Federal Rule of Civil Procedure 58, ordered that all claims in this case are remanded to the 67th Judicial District Court of Tarrant Co Tx – copy to 67th JD Tarrant Co (Signed by Judge Terry R Means on 06/09/03) (wrb,) (Entered: 06/11/2003)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
v.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

PLAINTIFF'S BRIEF IN SUPPORT OF
MOTION TO REMAND

January 25, 2001

George Parker Young
State Bar No. 22184750
Adam J. Williams
State Bar No. 24013753

FRIEDMAN, YOUNG, SUDER & COOKE
Mailing address:
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200 Bailey Ave., Suite 310
Fort Worth, Texas 76107
(817) 334-0400
(817) 334-0401 — fax

ATTORNEYS FOR PLAINTIFF

* * * *

[Page 1]

FACTUAL AND PROCEDURAL BACKGROUND

Juan Davila[2]

Juan Davila obtained his Aetna HMO health coverage through his employer, Monitronics, where he screens house-signaled house alarms.[3]

* * * *

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2 The factual allegations concerning Mr. Davila are found in Plaintiff's Original Petition at ¶¶ 11-15; their legal effect is outlined in ¶¶ 17-21.

3 In Plaintiff's Original Petition, Mr. Davila is erroneously identified as a member of Aetna's PPO. Mr. Davila is a member of Aetna's HMO. *See* Appendix in Support of Plaintiff's Motion to Remand, Tab 13 (APP 066).

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
FEB 14 2001
CLERK, U.S. DISTRICT COURT
By /s/
Deputy

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
V.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF RESPONSE AND BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION TO REMAND

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ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. and AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

CONTENTS

Exhibit A Affidavit of Pamela H. Deveau

Exhibit 1 Group Agreement between Aetna and Monitronics International Inc.

Exhibit 2 Certificate of Coverage between Aetna and Monitronics

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
V.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

AFFIDAVIT OF PAMELA H. DEVEAU

COUNTY OF ____ §
§
STATE OF TEXAS §

1. My name is Pamela H. Deveau. I am over the age of 21, I have never been convicted of a felony, and I am competent to make this affidavit.

2. I am a Benefit Consultant for Aetna U.S. Healthcare. In that capacity, I am familiar with and have access to various agreements between Aetna U.S. Healthcare of North Texas, Inc. ("Aetna") and employers that establish and maintain employee welfare benefit plans for the their employees and their eligible dependents. The statements contained in this affidavit are based on my personal knowledge and upon the business records of Aetna identified herein, and are true and correct.

3. Exhibit 1 to this affidavit is a true and correct copy of the Group Agreement between Aetna and Monitronics International Inc. ("Monitronics"). Exhibit 2 to this affidavit is a true and correct copy of the Certificate of Coverage between Aetna and Monitronics. As reflected in Exhibits 1 and 2 hereto, Monitronics established and maintains an employee benefit plan for the purpose of providing welfare benefits, including medical benefits, to its eligible employees and their dependents.

4. The medical benefits available under the plan are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 12-27.

5. The class of beneficiaries, *i.e.*, the Subscribers (employees) and their Covered Dependents, are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 8, 49, 53.

6. The claims procedures for receiving benefits and the claims appeal process are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 6, 35-39.

7. The source of financing for the plan is described in the Group Agreement. *See* Exhibit 1 at pp. 2-3.

8. Exhibits 1 and 2 and the attachments thereto were kept by Aetna in the regular course of business, and it was the regular course of business of Aetna for an employee or representative of Aetna, with knowledge of the act, event, condition, opinion or diagnosis, to make the records or to transmit information thereof to be included in such records, and the records were made at or near the time or reasonably soon thereafter.

Further Affiant Sayeth Naught.

/s/
Pamela H. Deveau

SWORN TO AND SUBSCRIBED BEFORE ME this 9th day of February, 2001.

[Seal]

/s/
Notary Public in and for
the State of Texas

[Exhibit 1 To Affidavit Of Pamela H. Deveau]

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT COVER SHEET

Contract Holder:	Monitronics International Inc.
Contract Holder Number:	148028 001 TX01
HMO Benefit Level:	CITIZEN PLAN Benefits Package
Group Agreement Effective Date:	December 1, 1999
Term of Group Agreement:	The initial term shall be: From December 1, 1999 to November 30, 2000 Thereafter, subsequent terms shall be: From December 1st to November 30th

Initial HMO Premium Rates:		
	Single	**$148.23**
	Parent & Child	**$276.66**
	Parent & Children	**$276.66**
	Couple	**$334.54**
	Family	**$459.94**

Term of Rates:	From December 1, 1999 to November 30, 2000. These rates are subject to adjustments based upon final regulatory

determinations.

Premium Due Dates:	The Group Agreement Effective Date and the 1st day of each succeeding calendar month.

NOTICE: Written notice shall be given by U.S. Mail, postage prepaid, to HMO at:

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
1650 Highway 6, Suite 200
Sugar Land, TX 77478
1-877-884-5518 toll free

and to Contract Holder at:

Monitronics International Inc
Ms. Kimberly Neal
Human Resource Assoc
Monitronics International Inc
12801 Stemmons Fwy, Ste 821
Dallas TX 75234-5835

_____
(Signature Date)

HMO(s):

By: _____/s/_____
David C. Kolton

Title: Vice President
Aetna U.S. Healthcare Inc.

Contract Holder:

By:_____(Signature)
_____(Printed Name)
Title:_____

Contract Holder Number: 148028
Contract Holder Locations: 001

Contract Holder Service Areas: TX01
Contract Holder Group Agreement Effective Date:
December 1, 1999

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT

This is a **Group Agreement** between Aetna U.S. Healthcare of North Texas Inc. (hereinafter referred to as "**HMO**") and Monitronics International Inc (hereinafter referred to as "**Contract Holder**").

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the terms, conditions, rights, and privileges as set forth in this **Group Agreement** and the Certificate of Coverage. **Members** covered under this **Group Agreement** are subject to all the conditions and provisions contained herein.

This **Group Agreement** is governed by applicable federal law and the laws of Texas.

If any provision of this **Group Agreement** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect. In consideration of the Premium payments made by or on behalf of the **Contract Holder**, **HMO** shall provide coverage for those services described in the Certificate of Coverage subject to the terms and conditions set forth in this **Group Agreement** and the Certificate of Coverage (herein after referred to as "**Certificate**") which is attached to this **Group Agreement**, and fully incorporated herein by reference. The terms and conditions used in this **Group Agreement** have the same meaning given those terms in the Certificate unless otherwise specifically defined in this **Group Agreement**.

Group Agreement Effective Date: December 1, 1999
Contract Holder Number: 148028

PREMIUMS

A. **Premiums** for the **Covered Benefits** under this **Group Agreement** are set forth in the Cover Sheet attached hereto, which is fully incorporated herein by reference.

B. The **Premiums** set forth in the Cover Sheet shall be effective for the initial term of this **Group Agreement**. Thereafter, if **HMO** gives a minimum of 30 days prior written notice to the **Contract Holder**, **HMO** may change the **Premiums**:

- upon the renewal date of this **Group Agreement**; or
- upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to **Members**.

Payment of the applicable **Premium** on and after that date shall constitute acceptance of those changes by the contract Holder, individually and on behalf of all **Members** enrolled under this **Group Agreement**.

C. **Premiums** are payable to **HMO** on or in advance of each **Premium** due date at the corporate offices of **HMO** unless otherwise specified by **HMO** in writing. The payment of any **Premium** shall not maintain coverage under this **Group Agreement** in force beyond the date when the next payment becomes due; however, a 31 day grace period, during which time this **Group Agreement** will remain in force, shall be granted for payment of each amount due after the first. The **Contract Holder** shall remain liable for the payment of the **Premium** for the time coverage was in effect during the grace period and the **Member** shall remain liable for **Copayments** owed. A check is not a payment until it is honored by a bank. **HMO** reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

D. Retroactive adjustments to the **Contract Holder's** billings may be made by **HMO** for the termination of **Members** not posted to previous **Contract Holder** billings. However, the **Contract Holder** may only receive a maximum of 2 month's credit for Member terminations which occurred more than 31 days prior to the date **HMO** was notified of such termination by the **Contract Holder**. Retroactive additions will be made at the discretion of **HMO** based upon eligibility guidelines, as detailed in the **Certificate** and on the Schedule of Benefits, and are subject to the payment of all applicable **Premiums**. As between **HMO** and the **Contract Holder**, the **Contract Holder** shall be responsible for any claims paid by **HMO** with respect to a **Member**, to the extent **HMO** relied on the **Contract Holder's** submitted enrollment to confirm coverage where coverage was not valid.

E. **Premiums** shall be paid in full for **Members** whose coverage is effective on the **Premium** due date or whose coverage terminates on the last day of the **Premium** period.

F. If the **Premiums** are not paid by the **Premium** due date, **HMO** will require the **Contract Holder** to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the 31st day after the **Premium** due date.

In the event of non-payment of any amount due, **HMO** shall be entitled to all remedies prodded for in law or in equity.

ENROLLMENT

Enrollment for eligible individuals, as described in the **Certificate**, will be permitted during the **Open Enrollment Period**, or within 31 days from the date the individual and any dependent becomes eligible for coverage. Completed enrollment information must be submitted to the **Contract**

Holder for transmittal to **HMO**. Eligible individuals and any eligible dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment**. Coverage shall not become effective until confirmed by **HMO**. The **Open Enrollment Period** shall be consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit representatives of **HMO** to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure.

There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the Schedule of Benefits.

The eligibility of the group, the composition of the group and the eligibility requirements used to determine membership in the group which exist at the effective date of this **Group Agreement** are material to the execution of this **Group Agreement** by **HMO**. The **Contract Holder** shall not during the term of this **Group Agreement** modify the **Open Enrollment Period**, the waiting period as described on the Schedule of Benefits, or any other eligibility requirements as described in the **Certificate** and on the Schedule of Benefits, for the purposes of enrolling the **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless agreed to in writing by **HMO**.

CONTRACT HOLDER TERMINATION

A. This **Group Agreement** may be terminated the **Contract Holder** on any **Premium** due date by giving 60 days' prior written notice.

B. The **Contract Holder** may terminate this **Group Agreement** as of its renewal date, by providing **HMO**

written notice of non-renewal not less than 60 days prior to the renewal date.

C. The **Contract Holder** may terminate this **Group Agreement** as of the date any Premium change would become effective, by providing **HMO** with written notice of termination not less than 30 days prior to such effective date.

D. **HMO** may terminate or non-renew the **Group Agreement** if:

1. **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Group Agreement** within the grace period. **HMO** may terminate this **Group Agreement** as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Group Agreement** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period;
2. the **Contract Holder** has performed an act or practice that constitutes fraud or intentional misrepresentation of a material fact in obtaining coverage under this **Group Agreement**;
3. The **Contract Holder** has failed to comply with a material plan provision relating to any employer contribution or group participation rules, under applicable state or federal law;
4. **HMO** ceases to offer coverage in the market in accordance with state law;
5. **HMO** ceases to offer coverage of a specific product in the market in accordance with state law;

6. the **Contract Holder** no longer has any enrollee under the plan who lives, resides, or works in the **Service Area**;

7. the **Contract Holder's** membership in the association, through which coverage is obtained, ceases.

E. Upon thirty days written notice to the **HMO**, the **Contract Holder** may terminate this **Group Agreement** in the case of a material change by the **HMO** to any provisions required to be disclosed to the **Contract Holder** or **Members** pursuant to State law.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Group Agreement**.

No change in the eligibility or participation requirements of the **Contract Holder** shall be permitted to affect eligibility or enrollment under this **Group Agreement** unless such change is agreed to by **HMO** and the **Contract Holder**, and is not otherwise contrary to applicable state or federal laws, rules or regulations. Breach of this provision is considered a material breach of this **Group Agreement** and may be the basis for termination by giving 60 days' prior written notice. It is the responsibility of the **Contract Holder** to notify the Subscribers of the termination of the **Group Agreement** in compliance with all applicable laws. However, **HMO** reserves the right to notify **Subscribers** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

INDEPENDENT CONTRACTOR RELATIONSHIPS

A. Between **Participating Providers** and **HMO**.

The relationship between **HMO** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **HMO** nor is **HMO** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.

B. Between the **Contract Holder** and **HMO**.

The relationship between **HMO** and the **Contract Holder** is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this **Group Agreement**.

ADMINISTRATION OF THE AGREEMENT

HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Group Agreement**.

A. Entire Agreement.

This **Group Agreement**, including the Group Application, Cover Sheet, Certificate of Coverage, Schedule of Benefits, any Riders, and any amendments, endorsements, inserts or attachments, constitutes the entire **Group Agreement** between the **Contract Holder** and

HMO, and on the **Effective Date of Coverage**, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by **HMO** for **Covered Benefits** provided by this **Group Agreement**.

All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **HMO** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

B. Amendments.

This **Group Agreement** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **HMO**, and this **Group Agreement** shall be deemed to be amended to conform therewith at all times. This **Group Agreement** may be changed at any time for any other reason by agreement between **HMO** and the **Contract Holder**, without the consent of any employee, **Member**, or other person. Except as detailed below, any amendments to this **Group Agreement** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **HMO**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **HMO** by making any other commitment or representation or by giving or receiving any information. No change in this **Group Agreement** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **HMO**.

Formal acceptance of an amendment to this **Group Agreement** by the **Contract Holder** shall not be required if:

1. the change was requested by either the **Contract Holder** or **HMO** and is agreed to in writing by the other; or
2. the change is required to bring the **Group Agreement** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Group Agreement** is delivered; or
3. the **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

C. Forms.

HMO shall supply the **Contract Holder** with a reasonable supply of its forms and descriptive literature. The **Contract Holder** shall distribute **HMO's** forms and descriptive literature to any eligible individual who becomes eligible for coverage. The **Contract Holder** shall, within 20 business days of receipt from an eligible individual, forward all applicable forms and other required information to **HMO**.

D. Records.

HMO shall maintain **Member** records. The records will contain key facts about the **Member's** coverage. Each month during the period of this **Group Agreement**, on forms approved by **HMO**, the **Contract Holder** shall furnish to **HMO** such information as may reasonably be required to administer the **Group Agreement**. This includes, but is not limited to, information needed to enroll **Members** of the **Contract Holder**, process terminations, and effect changes in

family status and transfer of employment of **Members**. **HMO** shall not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **HMO**.

The **Contract Holder** shall make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **HMO** for inspection, at **HMO's** expense, at the **Contract Holder's** office, during regular business hours, upon reasonable advance request from **HMO**. This provision shall survive the termination of this **Group Agreement** as necessary to resolve outstanding financial or administrative issues pursuant to this **Group Agreement**.

E. Clerical Errors.

Incorrect information furnished to **HMO** may be corrected, provided that **HMO** has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if **HMO**, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to **Members**. Upon discovery of such errors or delay, an adjustment of **Premiums** shall be made. In no case will adjustments in coverage or **Premiums** be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested addition, deletion, or change in coverage.

F. Claim Determinations.

HMO has complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **HMO** shall have discretionary authority to determine whether and to what ex-

tent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this **Group Agreement**. **HMO** shall be deemed to have properly exercised such authority unless **HMO** abuses its discretion by acting arbitrarily and capriciously.

G. Fraudulent or Intentional Misrepresentations.

If any relevant fact as to a **Member** is found to have been misrepresentation, an equitable adjustment of **Premiums** may be made. If the misrepresentation affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force.

H. Incontestability.

Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

1. No statement made by the **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
2. No statement made by the **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for 2 years from its effective date.
3. No statement made by a **Member** shall be used in defense of a claim for loss incurred or commencing after coverage has been in effect for 2 years.

I. Assignability.

No rights or benefits under this **Group Agreement** are assignable by the **Contract Holder** to any other party unless approved by **HMO**.

J. Waiver.

HMO's failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **HMO's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

K. Notices.

Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or Cover Sheet, or to any more recent address of which the sending party has received written notice.

L. Third Parties.

This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

M. Non-Discrimination.

The **Contract Holder** agrees to offer participation in **HMO** to all persons as described in the Subscriber Eligibility section of the Schedule of Benefits under terms and conditions no less favorable than those for any alternate health benefit plans. The **Contract Holder** agrees to make no attempt, whether through differential **Contract Holder Premium** contributions or otherwise to encourage or discourage enrollment in **HMO** of eligible

individuals and eligible **Dependents** based on health status or health risk.

N. Execution of this Agreement.

This **Group Agreement** shall be executed by **HMO** and the **Contract Holder** once the Group Application, which is attached hereto and fully incorporated herein by reference, is completed and signed. However, payment of the applicable Premium on and after the effective date of this **Group Agreement** shall constitute execution of this **Group Agreement** by the **Contract Holder**.

O. Inability to Arrange Services.

In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **HMO's Participating Providers** or entities with whom **HMO** has arranged for services under this **Group Agreement**, or similar causes, the rendition of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

P. Use of the HMO Name and all Symbols, Trademarks, and Service Marks.

HMO reserves the right to control the use of its name and all symbols, trademarks, and service marks presently existing or hereinafter established with respect to it. The **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or

promotional materials or otherwise without prior written consent of **HMO** and will cease any and all usage immediately upon request of HMO or upon termination of this **Group Agreement**.

Q. Worker's Compensation.

The **Contract Holder** is responsible for protecting **HMO's** interests in any workers compensation claims or settlements with any eligible individual. **HMO** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

At the signing of this **Group Agreement** and upon renewal, the **Contract Holder** shall submit proof of their worker's compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Worker's Compensation. The **Contract Holder** is also required to submit a monthly report to **HMO** listing all worker's compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individual.

R. Conflict Between **Group Agreement** and **Certificate**

Any direct conflict between the **Group Agreement** and the **Certificate** will be resolved according to the terms which are most favorable to the **Subscriber**.

[Exhibit 2 To Affidavit Of Pamela H. Deveau]

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)
2777 Stemmons Freeway, Suite 400
Dallas, Texas 75207
214-200-8000 or 1-800-992-7947

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna U.S. Healthcare of North Texas Inc., hereinafter referred to as HMO, and the Contract Holder. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial

capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

The Group Agreement under which this Certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THE GROUP AGREEMENT AND THE CERTIFICATE OF COVERAGE CONTAIN NO ARBITRATION PROVISION.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact HMO's Member Service Department at 1-800-992-7947.

You may call HMO's toll-free telephone number for information or to make a complaint at 1-800-992-7947

You may also write to HMO at:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact HMO first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener information o para someter una queja:

Puede comunicarse con su HMO Member Service Department al 1-800-992-7947.

Usted puede llamar al numero de telefono gratis de (company)'s para information o para someter una queja al 1-800-992-7947

Usted tambien puede escribir a HMO:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTES SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el HMO primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER:

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-228-1570.

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS:

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-228-1570.

Su queja sera referida a la agencia estatal que regula el hospital o centro de tratamiento para la dependencia quimica.

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HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access Covered Benefits as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf if a **Member** does not select a **PCP** at the time of enrollment, the **HMO** will assign a **PCP** to the **Member**. The **Member** retains the right to reject the **PCP** assigned the **Member** however the **Member** must select another **PCP** at the time of rejection. The **HMO** will, in good faith, assign a **PCP** located near to a **Member's** residence or place of employment.

A **Member** who has been diagnosed with a chronic, disabling or life threatening illness may apply to the **HMO's** Medical Director to be able to select a **Participating Specialist** as the **Member's PCP**. The **HMO** will specify to the **Member** the information necessary, including certification of the medical need, and signatures of the **Member** and the **Participating Specialist** interested in serving as the **Member's PCP**. The **Participating Specialist** must meet the **HMO's** requirements for **PCP** participation and be willing to accept the coordination of all the **Member's** healthcare needs. The designation of the **Participating Specialist** as the **Member's PCP** will not be retroactive. If the request for special consideration of a **Participating Specialist** is denied, a **Member** may appeal the decision through the **HMO's** established Grievance/Complaint Procedure.

B. **The Primary Care Physician**.

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

Should **Medically Necessary** covered services be unavailable through a **Participating Provider**, upon the request of the **Primary Care Physician** or **Participating Provider** and with prior approval of the **HMO**, a **Referral** may be made to a non-**Participating Provider** for those **Medically Necessary** covered services.

The **HMO** will allow for a review by a **Specialist** of the same or similar specialty as the type of **Physician** or **Provider** to whom the **Referral** was requested prior to the **HMO's** approval of the **Referral**.

C. **Availability of Providers**.

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**.

D. **Changing a PCP**.

A **Member** may change the **PCP** at any time by calling the **Member** Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request. The **Member** may change their **PCP** up to four times in a twelve month period.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination.

F. **Provider Communication.**

HMO will not prohibit, attempt to prohibit or discourage any **Health Professional** from discussing or communicating to a **Member** or a **Member's** designee any information or opinions regarding the **Member's** health care, any provisions of health care plan as it relates to the medical needs of the **Member** or the fact

that the **Health Professional's** contract with the **HMO** has terminated or will no longer be providing services under the **HMO**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

   b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, and dependents of dependents) who meets the eligibility requirements described on the Schedule of Benefits.

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services. Submission of complete enrollment information and **Premium** payment to **HMO** must be made within 31 days from the eligibility date.

1. **Newly Eligible Individuals and Eligible Dependents.**

An eligible individual and any eligible dependents who are eligible may enroll.

2. **Open Enrollment Period**

Eligible individuals or any dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. **Enrollment of Newly Eligible Dependents.**

   a. **Newborn Children.**

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, notification of the birth and any required additional **Premium** must be received by **HMO** not later than the 31st day after the date of birth. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

The coverage for newly born; adopted children and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

b. Adopted Children.

A legally adopted child, a child for whom a **Subscriber** is a court appointed legal guardian, or a child for which the **Subscriber** is a party in a suit in which the adoption of the child by the **Subscriber** is sought, and who meets the definition of a **Covered Dependent**, will be treated as a dependent. The **Subscriber** must make a written request for coverage within 31 days of the date the adoption is final or the legal guardianship has been decreed, or within 31 days after the **Subscriber** is a party in a suit for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The coverage shall be comparable to the coverage provided to other **Covered Dependents**. The child must meet the definition of a **Covered Dependent**, and the **Subscriber**

must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility as defined on the Schedule of Benefits; Dependent Eligibility In order to continue coverage for a handicapped child, the **Subscriber** must provide proof of the child's incapacity and dependency to **HMO** within 31 days of the date the child attains the limiting age. Subsequent proof may be requested by the **HMO**, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such coverage. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and

enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **Certificate**.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent's covered under another group health plan or self-funded employer health benefit plan when initially eligible for coverage under **HMO**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO** during the initial eligibility stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or

self-funded employer health benefit plan for one of the following reasons:

i. termination of employment; or
ii. reduction in the number of hours of employment; or
iii. termination of contributions toward the premium made by the employer, or
iv. death of a spouse or divorce; or

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the **HMO Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or pre-existing condition provision described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a **Covered Benefit** under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely

to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient Hospital Services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member services 800 telephone number listed on the **Member's** identification card

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.
2. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:
    a. call the **PCP's** office; and
    b. identify himself or herself as a **Member;** and
    c. follow the **PCP's** or covering **Physician's** instructions.

    If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care Benefits section of this **Certificate**.
3. Hospital visits.
4. Periodic health evaluations to include:
    a. well child care from birth including immunizations and booster doses of all immunizing

agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus; influenza type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law.

b. routine physical examinations.

c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

d. routine speech and hearing screenings.

e. immunizations (but not if solely for the purpose of travel or employment).

f. routine vision screenings.

5. Injections, including allergy desensitization injections.
6. Casts and dressings.
7. Health Education Counseling and Information.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.
2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gy-

necologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 and older, one routine mammography every year; or
- when **Medically Necessary**.

3. prostate cancer screening, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from his **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit

Prostate Cancer Screening benefits for male **Members** are provided as follows:

- age 40-49, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year, if the **Member** is at an increased risk of developing prostate cancer as determined by his physician; or
- age 50 and older, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.

- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. Open access includes care related to pregnancy; care for-all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition which is within the scope of the professional OB/GYN practice. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:
  1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
  2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
  3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
  4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers**.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area**

unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at participating **Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is prodded for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a **Physician**, registered nurse, or other appropriate licensed health care **Provider** and

may be provided at the mother's home, a health care **Provider's** office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A **Copayment** will not apply for home health care visits.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a **Member** following a mastectomy:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a mastectomy;
2. a minimum of 24 hours of inpatient care in a **Participating Hospital** following a lymph node dissection for the treatment of breast cancer.

A **Member** may request a shorter length of stay if the **Member's Participating Provider** determines the shorter stay to be appropriate.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these proce-

dures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Chemical Dependency Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification** and treatment of **Chemical Dependency**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or a controlled substance.

2. Inpatient care benefits in a **Participating Hospital** or treatment facility that is a **Participating Provider** are covered for the medical complications and treatment of **Chemical Dependency** and **Detoxification**. Benefits include medical treatment and referral services for **Chemical Dependency** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray, psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

J. **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers**.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. Benefits for **Serious Mental Illness**

Inpatient care received in a participating **Hospital** or **Participating Mental Health Treatment Facility** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** while the **Member** is a full-time inpatient is covered. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Outpatient care received from a **Participating Provider** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** is covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Any outpatient visits for the purpose of medication management will not be counted toward the maximum number of visits, and visits for medication management will be under the same terms and conditions as for outpatient visits for treatment of physical illness generally.

Coverage for **Serious Mental Illness** will include the same **Copayments** as for any other physical illness.

K. **Emergency Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**.

Benefits include:

a. a medical screening examination/evaluation, in accordance with any State or Federal law, the purpose of which is to determine whether an emergency medical condition exists;

b. the treatment and stabilization of the **Member** for the emergency medical condition;

c. services originating in a **Hospital** emergency facility or comparable facility following treatment or stabilization of an emergency medical condition, as approved by **HMO**. In addition, the **HMO** reserves the right to approved or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-**Participating Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

2. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

L. **Rehabilitation Benefits.**

A **Member** is covered for rehabilitation, services, and therapies benefits that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

M. **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Preauthorization must be obtained from the **Member's** attending

Participating Physician. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.
3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Physical, speech and hearing, or occupational therapy is covered.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house

are not covered. Coverage is not provided for **Respite Care**.

O. **Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

P. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an

HMO Participating pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ.

S. **Diabetes Related Benefits.**

Benefits for the treatment of diabetes and associated conditions. Coverage includes diabetes equipment, diabetes supplies and diabetes self-management training. All provisions applicable to other illness and surgical treatment, including **Copayments**, will apply to benefits for diabetes related coverage.

T. **Additional Benefits.**

Durable Medical Equipment Benefits. Durable Medical Equipment will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this

service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary** Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical

Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy.

- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibulopiasty treatment of periodontal disease, and dental implants are not covered. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts. Dental services and supplies for treatment of temporomandibular joint (TMJ) dysfunction except for diagnostic and medical/surgical treatment of TMJ.
- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
- Educational services and treatment of behavioral disorders, together with services for remedial education in-

cluding evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- **Experimental** or **Investigational Procedure**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or Investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

- False teeth.
- Hair analysis.
- Health services, specifically charges for health services, incurred before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**. This does not include covered services

resulting from complications of pregnancy incurred after the **Member's** effective date.

- Hearing aids.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools.
- Hypnotherapy, except when specifically approved by **HMO**.
- Implantable drugs.
- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg program or gestational carriers. This exclusion does not apply to artificial insemination, **Medically Necessary** services to diagnose and treat the underlying medical cause of **Infertility**, or donor sperm.
- Inpatient care for **Serious Mental Illness** which is not provided in a **Hospital** or **Mental Health Treatment Facility**; non-medical ancillary services and long-term rehabilitation services for **Serious Mental Illness**.
- Inpatient treatment for **Mental or Behavioral Conditions** unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive

treatment at government facilities and which facilities are reasonably available to the **Member**.

- Non-medically necessary services, including but not limited to, those services and supplies:

  1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  2. that do not require the technical skills of a medical, mental health or a dental professional;
  3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient prescription or non-prescription drugs and medicines unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and re-

agent strips, except that this exclusion does not apply to diabetes supplies.

- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private duty or special nursing care, unless preauthorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship, counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be trade.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  2. needles, syringes and other injectable aids, except that this exclusion does not apply to diabetes supplies;
  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but is not covered for a particular disease or injury under such law. that disease or injury will be considered "non-occupational" regardless of cause.

- Treatment of spinal disorder services, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or when it is a direct access benefit.
- Vision care services and supplies.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Services related to the care, filling, removal or replacement of impacted teeth.

B. **Limitations.**

In the event there are two or more alternative Medical Services which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly Medical Service, as determined by **HMO**, provided that **HMO** approves coverage for the Medical Service or treatment in advance.

Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA, however may be eligible for continuation of coverage as provided by subsection B of this section. Continuation of Coverage—State of Texas.

1. Minimum Size of Group:

   The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or

b. **Subscriber's** death, or

c. **Subscriber's** entitlement to Medicare benefits, or,

d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

a. the last day of the 18-month period.

b. the last day of the 36-month period.

c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

f. the date the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs

during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Member's** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6 Responsibility to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract Holder** and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage—State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

a. the death of the **Subscriber**,

b. the retirement of the **Subscriber**, or

c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid

Continuation of coverage under this section will terminate on the earliest to occur of:

a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;

b. the end of the 3 year period after the date of the divorce or legal separation;

c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. Group Continuation Privilege.

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder** within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

a. six months after the date the election is made;

b. the date on which failure to make timely payments would terminate coverage;

c. the date on which the group coverage terminates in its entirety;

d. the date on which the **Member** is or could be covered under Medicare;

e. the date on which the **Member** is covered for similar benefits by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;

f. the date the **Member** is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

C. Conversion Privilege.

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accor-

dance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA or state law, benefits as described in the COBRA Continuation Coverage or Continuation of Coverage—State of Texas sections of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of good health provided that **Member's** coverage under this **Certificate** terminated for one of the following reasons:

a. Coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder;** or

b. The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate**, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert; or

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age; or

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without punishing evidence of good health. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

D. Extension of Benefits While Member is Receiving Inpatient Care.

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay; or

2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached; or
4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or
5. 12 months from the termination date of the **Group Agreement**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

GRIEVANCE/COMPLAINT PROCEDURE

In situations when **Members** are dissatisfied with **HMO** services, the following procedures govern complaints, grievances, and grievance/complaint appeals made or submitted by **Members**. These complaints, grievances and grievance/ complaint appeals will be handled in a timely manner.

A. **Definitions.**

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided. **HMO** encourages **Members** to resolve an individual inquiry without the initiation of a Grievance/Complaint Review.

2. A "grievance/complaint" is any dissatisfaction expressed by a **Member** orally or in writing to **HMO** with any aspect of **HMO's** operation, including but not limited to:

   a. dissatisfaction with plan administration;

   b. appeal of an adverse determination;

   c. the denial, reduction, or termination of a service;

   d. the way a service is provided; or

   e. disenrollment decisions.

   A grievance/complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the **Member**.

B. **Grievance/Complaint Review.**

1. **HMO** will send the **Member** acknowledgment of the grievance/complaint within 5 business days of having received it. The acknowledgment will contain:

   i. the date of receipt of the grievance/complaint;

   ii. a description of **HMO's** grievance/complaint procedures and time frames;

   iii. a one-page complaint form, clearly stating that the grievance/complaint form must be returned to **HMO** for prompt resolution of the grievance/complaint, if the grievance/complaint is received orally;

   iv. requests for the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance/complaint; and

   iii. a notice informing the **Member** of the **Member's** right to have an uninvolved **HMO** repre-

   sentative assist the **Member** in understanding the grievance/complaint process.

   HMO will acknowledge, investigate, and resolve the grievance/complaint within 30 calendar days from the date of receipt of the written grievance or one-page grievance/complaint form.

2. The Grievance/Complaint Panel deciding the grievance/complaint shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance/complaint.

3. A written notice stating the result of the review by the Grievance/Complaint Panel shall be forwarded by **HMO** to the **Member**. Such notice shall include:

   a. a description of the Panel's understanding of the **Member's** grievance/complaint as presented to the Grievance/Complaint Panel (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

   b. the Panel's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and

   c. citations to the evidence or documentation used as the basis for the decision, including the specialization of any **Provider** consulted (i.e., reference to the **Certificate**, medical records, etc.);

d. if the decision is to deny services based on an adverse determination of **Medical Necessity**, the clinical bases used to reach that decision;

e. that the decision of the Grievance/Complaint Panel shall be final and binding unless appealed by the **Member** to **HMO** within sixty (60) days of the date of the notice of the decision of the Grievance/Complaint Panel; and

f. a full description of the appeals process and the time frames for the final decision on the appeal.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by the Appeal Panel, **HMO** shall provide the **Member** filing the appeal with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the **Member** to appear before the Appeal Panel. The appeal process gives the **Member** the opportunity to appear in person before the Appeal Panel or address the **Member's** issues through a written appeal to the Appeal Panel. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

   No less than 5 business days prior to the **Member's** appearing before the Appeal Panel, the **Member** will receive a copy of any documentation to be presented by the **HMO** staff; the specialization of **Physicians** or **Providers** consulted during the review, and the name and affiliation of all **HMO** representatives on the Appeal Panel. The **Member** may respond to this information for the Appeal Panel to consider in the **HMO's** deliberations.

2. The Appeal Panel shall be established by the Board of Directors of the **HMO** and shall be comprised of equal

numbers of non-employee **HMO Members**; **HMO** staff persons not previously involved in the disputed decision; and **Physicians** or **Providers** experienced in the area of care that is in dispute and who are independent of the **Physicians** or **Providers** who made the prior decision that resulted in the **Member's** appeal. If specialty care is in dispute, the appeal panel must include an additional person who is a **Specialist** in the field of care to which the appeal relates.

3. The Appeal Panel shall hold appeal hearings within the **Members** county of residence or the county where the **Member** normally receives the **HMO's** health care services. Another location may be used if in agreement by the **Member** and **HMO**.

4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance/Complaint Appeal Panel shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

5. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Panel shall have the right to exclude

redundant testimony or excessive argument by any party or witness.

6. A written recor . of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Appeal Panel shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.

8. The Appeal Panel shall render a written decision within 30 days of the conclusion of the appeal hearing. The decision shall contain:

   a. date of receipt of the oral or written request for appeal;

   b. a statement of the Appeal Panel's understanding of the nature of the grievance/complaint and the material facts related thereto;

   c. the Appeal Panel's decision and rationale, including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision;

   d. a summary of the evidence, including necessary document supporting the decision; and

   e. a statement of the **Member's** right to appeal to the Department of Insurance, with the following toll-free telephone number and complete address of the Department of Insurance:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714 – 9104
1 - 800 - 252 - 3439.

D. **Ongoing Emergency or Denial of Continued Stays for Hospitalization Appeals.**

Investigation and resolution of appeals related to ongoing emergencies or denials of continued stays for hospitalization grievances will be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed 1 business day from the **Member's** request for appeal.

Due to the ongoing emergency or continued hospital stay, and at the **Member's** request, **HMO** shall provide, in lieu of a grievance/complaint appeal panel, a review by a **Provider** not previously involved with the prior decision and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal. The **Provider** reviewing the appeal may interview the **Member** or the **Member's** designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within 3 days.

E **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Department of Insurance or

2. the filing of a complaint with the Department of Insurance; or

3. the establishing of any litigation or any administrative proceeding regarding either any alleged breach of the

Group Agreement or **Certificate** by **HMO**, or any matter within the scope of the grievance/ complaint resolution process of any complaint, grievance or grievance appeal.

F. **Record Retention.**

HMO shall retain the records of all grievances/complaints for a period of at least 7 years from the date of the receipt of the grievance/complaint. The records will include each grievance/complaint and any grievance/complaint proceeding and any actions taken on a grievance/complaint. A **Member** is entitled to a copy of the record on the applicable grievance/complaint and any grievance/complaint proceeding.

G. **Independent Review Organization (IRO).**

A **Member** whose appeal of an adverse determination is denied by **HMO** has the right to seek review of that determination by an IRO assigned to the appeal in accordance with state law. Not later than the third business day after the date that **HMO** receives a request for review, **HMO** will provide to the IRO the following:

1. any medical records of the **Member** that are relevant to the review;
2. any documents used by **HMO** in making the determination;
3. the written notification of the Appeal Hearing decision provided to the **Member;**
4. any documentation and written information submitted to **HMO** in support of the appeal; and
5. a list of each **Provider** who has provided care to the **Member** and who may have medical records relevant to the appeal.

HMO will comply with the IRO's determination with respect to the **Medical Necessity** or appropriateness of health care items and services for a **Member**, and pay for the independent review.

In a circumstance involving a **Member's** life-threatening condition, the **Member** is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of **HMO's** adverse determination. A life-threatening condition is a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

H. **Fees and Costs.**

Nothing herein shall be construed to required **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance/complaint or appeal.

I. **HMO** may not refuse to renew or cancel coverage of the **Contract Holder** or a **Member** or take any other retaliatory action because the **Contract Holder** or a **Member** has filed a grievance/complaint or appealed a decision made by **HMO**. Also, **HMO** may not refuse to renew or terminate a contract with a **Participating Provider** or **Participating Physician** in retaliation for the filing of a grievance/complaint or appeal of a decision made by **HMO**, on behalf of the **Contract Holder** or a **Member**.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**.

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans

will pay benefits must be figured. This will be done as follows using the fast rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

    1. secondary to the plan covering the person as a dependent; and

    2. primary to the plan coveting the person as other than a dependent;

    the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

        1. covers the person as other than a dependent; and

        2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

    If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not

agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

    1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

    2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

    3. If there is not such a court decree:

    If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

    If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or
2. the dependent of such person,

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or
2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision as permitted by State or Federal law.

Other plan means any other plan of health expense coverage under:

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional "fault" auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an Allowable Expense unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determines its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

Medicare benefits will be taken into account for any **Member** who is eligible for Medicare. This will be done whether or not the **Member** is enrolled in Medicare.

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Dependents** who are eligible for Medicare. When a active **Subscriber**, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Retired Employees and Their Dependents Who Are Eligible For Medicare.

If the eligible class of employees of this **Certificate** includes coverage for retired employees who are eligible for Medicare, the benefits provided by this **Certificate** will be paid in accordance with the Provision for Coordination with Medicare section below.

Provision for Coordination with Medicare.

Benefits under this **Certificate** will cease for any **Member** eligible for Medicare. If coverage would cease because a **Subscriber** is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's Compensation) any benefits in force for the **Subscriber's Covered Dependents** may be continued. Coverage will then continue until it terminates for some other reason under the rules of this **Certificate**. A conversion privilege may be available in the event that a **Dependent's** coverage under this **Certificate** ends because the **Subscriber** becomes eligible for Medicare. This does not apply if the **Member** is eligible for any Medicare related benefits under this **Certificate**.

SUBROGATION

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which the third party is or may be responsible. **HMO** receives all rights of recovery acquired by a **Member** against any person or organization for negligence or any willful act resulting in illness or injury covered by the **HMO Covered Benefits**, but only to the extent of these **Covered Benefits**. Upon receiving such **Covered Benefits** from the **HMO**, the **Member** has considered to have assigned such rights of recovery to the **HMO** and to have agreed to give the **HMO** any reasonable help required to secure the recovery. The recovery may include attorney fees and court costs if applicable.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**.

B. **Reports and Records. HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;
2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**.

No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider** or other **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all Medical Services which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In

the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

a within thirty days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the **Provider** Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. During the first two years, coverage can be voided for material misrepresentation contained in a written application. After two years, coverage can be voided only in the event of a fraudulent misstatement contained in the written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. If this **Certificate** contains any provision not in conformity with Texas state law or other applicable laws it

shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be actively at work on a non-scheduled work day only if such person is actively at work on the last regularly scheduled work day immediately preceding such non-scheduled work day.
- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Behavioral Health Provider**. A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Certificate**. This **Certificate** of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Chemical Dependency**. The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

- **Chemical Dependency Rehabilitation.** Services, procedures and interventions to eliminate the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance, according to individualized treatment plans.
- **Contract Holder**. An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment**. A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.

- **Copayment** Maximum. The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery**. Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Dependent**. Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program

(FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and

adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Detoxification**. The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment**. Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures**. Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
  7. it is provided or performed in special settings for research purposes.

- **Group Agreement**. The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
- **Health Professionals**. A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services**

which are within the scope of the individual's license or certificate.

- **HMO**. Aetna U.S. Healthcare of North Texas Inc., a Texas corporation licensed by the Texas Department of Insurance as a Health Maintenance Organization.
- **Homebound Member**. A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.
- **Home Health Services**. Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
- **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.
- **Hospital**. An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
- **Infertile or Infertility**. The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does

not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
- **Medical Emergency**. The recent onset of a medical condition of severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
  1. placing the patient's health in serious jeopardy,
  2. serious impairment to bodily functions;
  3. serious dysfunction of any bodily organ or part;
  4. serious disfigurement; or
  5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

  Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, loss of consciousness, injuries involving treatment to the mouth and teeth, and conditions that have progressed from a non-emergent situation initially to that of an emergent nature over a period of time, of a few days to as long as a week.
- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate

and consistent with the diagnosis in accordance with accepted medical standards as described in the **Covered Benefits** section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.

- **Member**. A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.
- **Mental Health Treatment Facility:** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medical services that may be

required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Open Enrollment Period**. A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month, except that if the month is February, the period shall last through March 2.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating**. A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician**. A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and

who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **Premium**. The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician**. A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider**. A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital**, or **Medical Services** to **Members**.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Referral**. Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Respite Care**. Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

- **Serious Mental Illness**: means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- **Service Area**. The geographic area, established by **HMO** and approved by the appropriate regulatory authority.
- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.
- **Skilled Nursing Facility**. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the Americ .n Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.
- **Specialist**. A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber**. A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the **Premiums** section of the **Group Agreement**.

- **Totally Disabled or Total Disability**. A **Member** shall be considered Totally Disabled if:

  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or

  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

[CERTIFICATE OF COVERAGE AMENDMENT]

* * * *

COVERED BENEFITS

The following is added to Section B of the Covered Benefits section of the **Certificate**:

4. **Osteoporosis Benefits**. Bone mass measurement by a **Participating Provider** to determine a **Qualified Individual's** risk of osteoporosis and fractures associated with osteoporosis is covered. The Member is required to obtain a **Referral** from his or her **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

   A **Copayment** and a maximum annual out-of-pocket payment, may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

The following replaces Section G of the Covered Benefits section of the **Certificate**:

G. **Transplants**.

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a

live donor, to the extent these services are not covered by another plan or program. The **Member** will not be required to travel out-of-state to receive transplant services unless the **HMO** obtains the informed consent of the **Member**.

The following replaces Section L of the Covered Benefits section of the **Certificate**:

L. **Rehabilitation Benefits**.

A **Member** is covered for rehabilitative services and physical, speech and occupational therapies that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

The following replaces Section R of the Covered Benefits section of the **Certificate**:

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ. For purposes of this benefit, the temporomandibular joint includes the jaw and the craniomandibular joint.

The following is added to Section T of the Covered Benefits section of the **Certificate**:

- **Reconstructive Breast Surgery Benefits**. Reconstructive breast surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including aereolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and medically necessary physical therapy to treat the complications of mastectomy, including lymphedema.

A **Copayment** and a maximum annual out-of-pocket payment, may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

The following replaces the cosmetic surgery exclusion of the Exclusions and Limitations section of the Certificate:

- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy, including the breast

on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed.

TERMINATION OF COVERAGE

The following replaces Section A.3 of the Termination of Coverage section of the **Certificate**:

1. the **Subscriber** is no longer eligible as outlined on the Schedule of Benefits or this **Certificate**; or

The following replaces Section B.1 of the Termination of Coverage section of the Certificate:

1. a **Covered Dependent** is no longer eligible, as outlined on the Schedule of Benefits or this **Certificate**;

The following replaces Section C.3 of the Termination of Coverage section of the **Certificate**:
upon 15 days advance written notice, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed fraud against **HMO**, including fraud in the use of services or facilities. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. In the absence of fraud, all statements made by a **Subscriber** applying for coverage under this **Certificate** will be deemed representations and not warranties. Coverage can be voided for fraud or intentional misrepresentation contained in a written application. A copy of the written application must be furnished to the **Subscriber** if the terms of the application or enrollment form are to be applied.

CONTINUATION AND CONVERSION

The following replaces Section A.4 of the Continuation and Conversion section of the **Certificate**:

4. Continuation coverage under this **Certificate** ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

   d. the first day on which the **Group Agreement** between **Contract Holder** and **HMO** is not in full force and effect.

   e. the first day on which the **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

   f. the date the **Member** is entitled to Medicare.

The following is added as Section B.3 to the Continuation and Conversion section of the Certificate:

3. **Texas Health Insurance Risk Pool**

   A **Member** may be eligible for coverage under the Texas Health Insurance Risk Pool. Prior to the end of the **Member's** coverage under the "Continuation of Coverage—State of Texas" section of this **Certificate**, **HMO** will provide the **Member** with the Texas

Health Insurance Risk Pool's address and toll-free telephone number.

Coverage provided under this Amendment may be terminated in accordance with the provisions stated in the "Termination of Coverage" section of the **HMO Certificate of Coverage**, including, but not limited to, payment of the required **Premium** for this benefit.

This Amendment shall not vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the **HMO Certificate of Coverage**, other than as stated above.

GENERAL PROVISIONS

The following replaces Section J of the General Provision section of the **Certificate**:

J. **Incontestability**. In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. Coverage can be voided for fraud or intentional misrepresentation contained in a written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
(TEXAS)

INPATIENT MENTAL HEALTH RIDER

Contract Holder Group Agreement Effective Date: December 1, 1999

Aetna U.S. Healthcare of North Texas Inc., ("**HMO**") and **Contract Holder** agree to offer to **Members** the HMO inpatient Mental Health benefit, subject to the following provisions:

The Definitions section of the **Certificate** is amended to include the following definitions:

Crisis Stabilization Unit: A 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions, and which is provided by a facility that is licensed or operated by the appropriate state agency or board to provide such services.

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Mental Health Treatment Facility: A facility that: a) meets licensing standards; b) mainly provides a program. for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medi-

cal services that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.

Partial Hospitalization: The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

Residential Treatment Center. A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, Healthcare Operations, or the American Association of Psychiatric Services for Children, and which is licensed or operated by the appropriate state agency or board to provide such services.

Section J of the Covered Benefits section of this **Certificate** is amended to add the following provisions:

3. Inpatient benefits are covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital residential facility including a **Mental Health Treatment Facility, Crisis Stabilization Unit**, or **Residential Treatment Center** appropriately licensed by the Department of Health or its equivalent. Coverage is subject to the maximum number of days, if any, shown on the below, however **Coverage** will not be less favorable

than for hospital coverage under your particular plan of benefits.

Inpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO**, 1 mental health inpatient day, if any, may be exchanged for up to 2 outpatient or home health visits up to the maximum benefit limitation upon approval by **HMO**.

One (1) inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by **HMO** prior to utilization.

Benefits are in conjunction with the **Member's Individual Treatment Plan**.

Copayment
The **Member** is responsible for a **Copayment** and Maximums as follows:

$500 per admission

Maximum of 30 days per Contract Year

MISCELLANEOUS PROVISIONS

Section C of the Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

Inpatient Mental Health - The conversion privilege does not apply to the HMO Inpatient Mental Health benefit.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC. (TEXAS)

PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date: December 1, 1999

Aetna U.S. Healthcare of North Texas Inc. ("**HMO**") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Plan, subject to the following provisions:

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Brand Name Prescription Drug(s) or Medicine(s)** - A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate. **Brand Name Prescription Drugs or Medicines** do not include those drugs classified as **Generic Prescription Drugs or Medicines** as defined below.
- **Contracted Rate** - The negotiated rate between **HMO** or an affiliate and the **Participating Pharmacy**.
- **Drug Formulary** - A listing of prescription medications established by **HMO** or an affiliate. This list is distributed to **Participating Providers** and is subject to periodic review and modification by **HMO** or an affiliate. An updated copy of the **Drug Formulary** shall be available at any time upon request by the **Member**. A **Drug Formulary** may be managed as "closed", "open", or "differential copay" based upon the benefit design of the **Member's HMO** Prescription Plan.
- **Generic Prescription Drug(s) or Medicine(s)** - A prescription drug, whether identified by its chemical,

proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

- **Maintenance Drugs** - A listing of prescription drugs or medications established by **HMO** or an affiliate which is subject to periodic review and modification by **HMO** or an affiliate. The list consists of prescription drugs or medications that are taken for extended periods of time, and which do not vary frequently in terms of dosage (such as high blood pressure medication).
- **Participating Mail Order Pharmacy** - An establishment which has contracted with **HMO** or an affiliate, and where prescription drugs or medicines are legally dispensed by mail.
- **Participating Pharmacy** - A community pharmacy which has contracted with **HMO** or an affiliate to provide prescription services to **Members**.

A. **Outpatient Prescription Triple Copayment Benefit**.

1. Outpatient prescription drugs or medicines are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The list of covered prescription drugs or medicines is subject to change from time to time at the sole discretion of **HMO**. Except for **Maintenance Drugs** as indicated below, each prescription is limited to a maximum 34 day supply, with up to a refills when authorized by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. Prescriptions must be filled at a **Participating Pharmacy**.

   The **Member's Copayment** is based on the usage or non-usage of **HMO's** or an affiliate's **Drug Formulary**, which includes both **Brand Name Prescription Drugs or Medicines** and **Generic Prescription Drugs or Medicines** approved by **HMO** or an affiliate.

Prescription drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

The **Member** is responsible for a **$10 Copayment** per prescription or refill for a **Generic Prescription Drug or Medicine**.

The **Member** is responsible for a **$15 Copayment** per prescription or refill for a **Brand Name Formulary Prescription Drug or Medicine**.

The **Member** is responsible for a **$30 Copayment** per prescription or refill for a **Brand Name non-Formulary Prescription Drug or Medicine**.

The **Copayment** is payable directly to the **Participating Pharmacy** for each prescription at the time the prescription is dispensed. The **Copayment** is not subject to the Annual Maximum Out-of-Pocket Limit set forth in the Schedule of Benefits, if any.

2. Coverage for **Maintenance Drugs**, beyond the 34-day supply, is available under this Prescription Plan benefit. To be covered on this extended basis, the prescription drug must be a **Maintenance Drug** on the list of drugs approved by **HMO** or an affiliate and appropriate for the **Member's** illness or injury. The prescription must be originally filled for up to a 34 day supply by the **Participating Pharmacy** and be covered under this Rider. Thereafter the **Maintenance Drug** is covered for up to a 90 day supply upon a written prescription by a **Provider** licensed to prescribe federal legend prescription drugs or medicines provided the strength or form is not changed. If the prescription is not refilled within 45 days after total utilization based upon the **Provider's** prescribed directions, the next refill will be considered an initial prescription, and will be covered up to a maximum 34 day supply. All 90 day supply prescriptions must be filled by the **Participating Pharmacy**. This list is subject to change in **HMO's** or an affiliate's sole discretion, without notice to **Members** or **Contract Holder**.

   Copayment: **If the Member obtains more than a 34-day supply of prescription drugs or medicines, not to exceed a 90-day supply, two Copayments are payable for each supply dispensed.**

B. **Emergency Prescriptions Out-of-Area** - If an emergency prescription is needed when the Member is located beyond a 50-mile radius from the **HMO Service Area**, **HMO** will reimburse, subject to professional review, the cost of the prescription, less the **Copayments** specified in Section A above if a non-participating pharmacy is used. If the Member uses a **Participating Pharmacy** located outside the **HMO Service Area**, the

Member will be subject to the **Copayment** listed in Section A above.

C. **Additional Optional Benefits**.

The following prescription drugs, medicines, and supplies are also covered:

- **Contraceptives.**

  The following contraceptives and contraceptive devices are covered upon prescription or upon the **Participating Physician's** order only at a **Participating Pharmacy**:

  1. Diaphragms, one per 365 day period.
  2. Depo provera. The prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per 365 consecutive day period.
  3. Norplant and IUDs are covered when obtained from a Participating **Physician**. The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any.

- **Mail Order Prescription Drugs and Medicines**. Outpatient prescription drugs or medicines are covered when dispensed by a licensed **Participating Mail Order Pharmacy** and require a prescription drug or medicine order by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. Outpatient prescription drugs and medicines will not be dispensed in quantities that are less than a 34 day supply or more than a ninety (90) day supply.

The **Member** is responsible for the **Copayment** listed in Section A above for prescription drugs or medicines dispensed by a **Participating Mail Order Pharmacy**. The **Copayment** is payable directly to the **Participating Mail Order Pharmacy** for each dispensed order. The **Copayment** is not subject to the Annual Maximum Out-of-Pocket Limit set forth in the Schedule of Benefits, if any.

Copayment: If the Member obtains more than a 34-day supply of prescription drugs or medicines, not to exceed a 90-day supply, two Copayments are payable for each supply dispensed.

The Limitations and Exclusions section of the **Certificate** is amended to include the following limitations and exclusions:

A. **Exclusions**.

Unless specifically covered under this Rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug even when a prescription is written.)
2. Any charges for the administration of prescription legend drugs and other injectable drugs covered by **HMO**.
3. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to, Retin A for wrinkles, health and beauty aids.
4. Needles and syringes.
5. Any medication which is consumed or administered at the place where it is dispensed, except when dispensed and consumed at a **Participating Pharmacy**.
6. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or

other blood products administered on an outpatient basis, allergy sera and testing materials.
7. Drugs used for the purpose of weight reduction (i.e. appetite suppressants).
8. Any prescription drug for which the actual charge to the recipient is less than the required **Copayment** or which applies to the Deductible Amount or for any drug for which no charge is made to the recipient.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than one (1) year from the date the latest prescription order was written; or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
13. Test agents and devices.
14. Smoking cessation aids.
15. Injectable drugs used for the purpose of treating infertility.
16. Injectables.
17. Non-oral and implantable contraceptive drugs and contraceptive devices.
18. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this Rider.

B. **Limitations**:

A **Participating Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Section C of the Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

The conversion privilege does not apply to the **HMO** Prescription Plan.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date:
December 1, 1999

The Aetna U.S. Healthcare Inc. Prescription Plan Rider is hereby amended as follows:

The Exclusions and Limitations section of the Prescription Plan Rider is hereby amended to include the following exclusion:

19. Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy, including but not limited to, sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms, any prescription drug in oral or topical form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
20. Performance, athletic performance or lifestyle enhancement drugs and supplies.
21 Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO**.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

SCHEDULE OF BENEFITS

Plan Name: CITIZEN PLAN
Contract Holder Name: Monitronics International Inc
Contract Holder Group Agreement Effective Date:
December 1, 1999
Contract Holder Number: 148028
Contract Holder Locations: 001
Contract Holder Service Areas: TX01

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Office Visit	
During Office Hours	**$15 per visit**
Non-Office Hours and Home Visits	**$20 per visit**
Well Child Care	**$15 per visit**
Specialist Physician Office Visit	**$25 per visit**
Outpatient Rehabilitation Benefits	**$25 per visit**
First OB Visit	**$25 per visit**
Routine Gynecological Exam(s)	
1 visit(s) per 365-day period	**$25 per visit**
Hospital Outpatient Department Visit and Diagnostic Testing	**$25 per visit**
Outpatient Emergency Services	
Hospital Emergency Room or Outpatient Department	**$50 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Health Visits	
20 visits per calendar year	**$25 per visit**
Outpatient Serious Mental Illness Visits	
60 maximum visits per calendar year	**$25 per visit**

Benefit	Copayment
Outpatient Chemical Dependency Visits	
Detoxification and Rehabilitation	**$25 per visit**
Subject to the same Copayment as for physical illness.	
Three Treatment Episodes for inpatient hospital and treatment facility, **Partial Hospitalization** and outpatient treatment in a **Member's** lifetime. A "Treatment Episode" is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. A Treatment Episode is complete when the **Member** is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, **Partial Hospitalization** or intensive outpatient or a series of these levels of treatments without a lapse in treatment; or when a **Member** fails to materially comply with the treatment program for a period of 30 days.	
Outpatient Surgery	**$100 per visit**
Outpatient Home Health	**$0 per visit**
Hospice Visits	
365 visits per calendar year	**$0 per visit**
Injectable Medications	**$15 per item**

INPATIENT BENEFITS

Benefit	Copayment
Acute Care **Serious Mental Illness** Maximum of **45** days per calendar year **Maternity** **Skilled Nursing Facility** Maximum of 365 days per calendar year **Hospice** **Chemical Dependency-Detoxification and Rehabilitation** Subject to the same Copayment as for physical illness. Three Treatment Episodes for inpatient hospital and treatment facility, **Partial Hospitalization** and outpatient treatment in a **Member's** lifetime. A "Treatment Episode" is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. A Treatment Episode is complete when the **Member** is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, **Partial Hospitalization** or intensive outpatient or a series of these levels of treatments without a lapse in treatment; or when a **Member** fails to materially comply with the treatment program for a period of 30 days.	**$500 per admission**

ADDITIONAL BENEFITS

Benefit	Copayment
Routine Eye Exam as per schedule in certificate	**$25 per visit**
Durable Medical Equipment Benefits:	
Copayment	**$0 per item**
Maximum Annual Out-of-Pocket	**$0 per Member, per Contract Year**
Maximum Annual Benefit	**Unlimited per Member, per Contract Year**

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

FILED
U.S. DISTRICT COURT
NORTHERN DISTRICT OF TX.
FT. WORTH DIVISION

2001 MAR -9 PM 2:15

CLERK OF COURT

JUAN DAVILA	§	
	§	
Plaintiff,	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
v.	§	
	§	
AETNA U.S.	§	Plaintiff's Response to
HEALTHCARE, INC.	§	Aetna's Motion to Dismiss
AND AETNA U.S.	§	and Plaintiff's Reply to
HEALTHCARE OF	§	Aetna's Response to Plain-
NORTH TEXAS, INC.,	§	tiff's Motion to Remand, And
	§	Brief in Support Thereof
Defendants.	§	

PLAINTIFF'S RESPONSE TO AETNA'S MOTION TO DISMISS AND PLAINTIFF'S REPLY TO AETNA'S RESPONSE TO PLAINTIFF'S MOTION TO REMAND, AND BRIEF IN SUPPORT THEREOF

March 9, 2001

George Parker Young
State Bar No. 22184750
Adam J. Williams
State Bar No. 24013753

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ATTORNEYS FOR PLAINTIFFS

[Pages 5-6]

* * * *

Despite the dubiousness of *Corcoran*'s continued validity, Plaintiff would understand if this Court chose to leave it to a higher court to determine that *Corcoran* is no longer valid law, particularly in light of the cases Aetna cites which rely on *Corcoran* or on its now-faulty analysis that a "mixed medical decision" equals a benefits-denial.[5] If this Court denies Plaintiff's Motion to Remand, it should also dismiss this case *sua sponte* in order to permit this matter to be immediately appealed since Plaintiff *will not* be amending to add ERISA claims for denied benefits—such a claim would violate Fed. R. Civ. Pro. 11 as a frivolous claim, since Mr. Davila's claim is not based on something that was denied, but what he received. But Plaintiff wants to be clear: this

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[5] *See, e.g., Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999); *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996). As demonstrated herein, however, none of the cases cited by Defendants address the fundamental change in ERISA preemption analysis instigated by the Supreme Court trilogy, nor address *Pegram* or the legislative history of the Federal HMO Act.

Court can appropriately rule that *Corcoran*'s mixed-decision analysis is now flawed in light of *Pegram*, and remand based on a lack of subject matter jurisdiction.[6]

* * * *

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6 *See* Plaintiff's Appendix in Support of Plaintiff's Motion to Remand, Exhibits 1-11 (Northern District decisions remanding similar claims). The mischief wrought by confusing conflict and complete preemption is addressed in *Giles v. NYLCare*, 172 F.3d 332, 338 (5th Cir. 1999), where Justice Smith admits the Court got it wrong in *Burks v. Amerada Hess*, 8 F.3d 301 (5th Cir. 1993) which held that a court cannot remand claims which are merely conflict preempted.

The problem with remanding this matter is that it puts off for another day presenting a case to the Fifth Circuit which squarely demands that it overrule *Corcoran*, which was decided at the height of ERISA preemption, before the Supreme Court and Fifth Circuit radically revamped the ERISA preemption analysis.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. District Court
Northern District of Texas
FILED

MAR-9 2001
CLERK, U.S. DISTRICT COURT
By_____
Deputy

JUAN DAVILA	§	
	§	
Plaintiff,	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
v.	§	
	§	
AETNA U.S.	§	Plaintiff's Second Appendix
HEALTHCARE, INC.,	§	In Support of Remand
ET AL.,	§	
	§	
Defendants.	§	

PLAINTIFF'S SECOND APPENDIX IN SUPPORT OF REMAND

March 9, 2001

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[EXHIBIT 2: Aetna Inc. and Aetna U.S. Healthcare Inc.'s Memorandum of Law in Support of Defendants' Motion to Dismiss the First Amended Complaint, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

[Pages 17-19]

* * * *

State regulation of HMOs is even more extensive. As relevant to the states in which the named Plaintiffs reside, neither the Texas nor Mississippi Department of Insurance will grant a certificate of authority to an HMO unless it has met standards relating to both its rates and its disclosure documents. Thus, Texas law allows the cost-containment practices challenged by Plaintiffs, while regulating them to ensure they do not have the detrimental effects alleged. For example, Texas law "does not prohibit the use of capitation as a method of payment." TEX. INS. CODE art. 20A.14(k)(1). Indeed, Texas law regulates capitation extensively to assure that amounts are "sufficient to compensate the primary care physician . . . for the risk being assumed" and do not result in the denial of necessary medical services. *Id.* art. 20A.18A(e)(4). Texas law further allows utilization to determine whether requested medical services are indeed medically necessary, *see id.* art. 2A.02(a), and specifically contemplates the use of third-party utilization review agents, *see id.* art. 21.58A(3)(a).

The disclosure requirement of Texas's HMO-certification rules requires managed-care companies to file with the Department of Insurance ("DOI") a copy of the certificates of coverage to be provided to enrollees, as well as copies of group contract materials provided to purchasers of coverage, copies of all "contract[s] made or to be made between any provider [or] physician" and the managed care company, and

"a written description of the types of compensation arrangements" used by the company. *Id.* art. 20A.04(a0(4)-(6), (15). The DOI must deny a certificate of authority to any managed-care company whose filed documents are in any way "unjust, unfair, inequitable, misleading, deceptive, [or] which encourage misrepresentation." *Id.* arts. 20A.09(a)(3)(A). Finally, managed care companies must file their rate methodologies with the DOI. *See id.* arts. 20A.09(k). The rate methodologies must produce charges that are not "excessive, inadequate, or unfairly discriminatory," *id.*, and the DOI may disapprove rates that do not meet these statutory standards. *See id.* art. 20A.09(*l*).[8]

Like Texas law, the Mississippi certification requirement for HMOs contains both substantive and disclosure components. Substantively, Mississippi law expressly permits the categories of practices challenged by Plaintiffs. It permits capitation, *see* MISS. CODE ANN. § 83-41-325, and authorizes managed-care companies to use outside private utilization-review firms. *See id.* §§ 41-83-1, 41-83-3, 41-83-5.[9] The

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8 When making a rate adequacy determination, the Insurance Commissioner must consider information about, *inter alia*, "the cost of health care services and benefits provided by the coverage if the same coverage were provided on a private pay basis, considering community average rates for such services and benefits within the service area of the plan," administrative expenses, assumed or actual utilization levels, and group demographics. 28 TEX. ADMIN. CODE § 11.706(b).

9 Managed care plans must submit a summary of their utilization review policy for the State's review. MISS. CODE ANN. § 83-41-409(a)(ii). In addition, utilization review agents themselves are subject to specific requirements. Such third parties must apply for state certification by submitting to the Department of Insurance "a description of review criteria, standards, and procedures" for evaluating requests for medical care. *Id.* § 41-83-9.

disclosure component of Mississippi's managed-care-certification rules requires that all health-maintenance contracts, certificates, and member handbooks—the very "disclosure documents" on which Plaintiffs rest their allegations of nondisclosure and misrepresentation (*see* Compl. ¶ 7)—be submitted to the Insurance Commissioner for prior approval. *See* MISS. CODE ANN. § 83-41-305(3)(3). Managed-care companies are also required to file their proposed rates with the Commissioner for prior approval. *See id.* § 83-41-331. As with misleading "disclosure documents," the Commissioner is required to disapprove any rate schedule that is "excessive, inadequate or unfairly discriminatory." *Id.* § 83-41-331(2).

* * * *

[Pages 38-40]

C. The McCarran-Ferguson Act Pre-Empts The Complaint's RICO Claims

The McCarran-Ferguson Act pre-empts federal civil RICO claims where "RICO's application to the . . . claims at issue [would] 'invalidate, impair, or supersede' [state] laws regulating insurance." *Humana, Inc. v. Forsyth*, 119 S. Ct. 710, 716 (1999) (quoting 15 U.S.C. § 1012(b)). RICO impairs state laws regulating insurance if its application in a particular case would "frustrate any state policy" or "interfere with a State's administrative regime." *Id.* at 719. Because those consequences would plainly ensue here were this Court to entertain Plaintiffs' RICO challenge, that challenge is barred by the McCarran-Ferguson Act.

That point is evident from even a brief overview of the regulatory regime applicable to managed care companies in

Texas, where Plaintiff O'Neill resides. The Texas Commissioner of Insurance has directed what information insurers should disclose to current or prospective HMO enrollees.[18] The Plaintiffs, however, ask this Court to find that disclosures that have been approved by the Commissioner amount to fraud, extortion and other federal crimes actionable under civil RICO. Texas has expressly authorized insurers to enter into contracts that give physicians financial incentives to provide cost-effective care. TEX. INS. CODE art. 20A.14(k)(1); *id.* art. 20A.18A(e)(4). But the Plaintiffs ask this Court to find those same contracts to be extortionate under RICO.

Similarly, Texas, like many other states, reviews insurers' rate methodologies to insure that they are neither excessive nor inadequate in light of the coverage being provided and other relevant circumstances, thus fulfilling the traditional state regulatory goal of assuring that customers will be charged fair rates that are also sufficient to preserve the solvency of the insurer. *See id.* art. 20A.09(k)-(*l*); *see also* 28 TEX. ADMIN. CODE § 11.706(b). Yet the entire point of Plaintiffs' RICO suit is to establish that the rates charged are *un*reasonable in light of the true value of "coverage" actually provided. In short, Plaintiffs RICO claims call into question virtually every aspect of the state's regulatory structure and seek, as their very object, to supplant that structure with a set of judicially-imposed disclosure duties and rate methodologies. The McCarran-Ferguson Act precludes precisely such

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[18] TEX. INS. CODE ANN. § 20A.11(b) (West Supp. 1999); *see also* 28 TEX ADMIN. CODE § 11.506(1)-(26); *id.* § 11.1600(b)(1)-(12).

RICO claims. *See LaBarre v. Credit Acceptance Corp.*, 175 F.3d 640, 643 (8th Cir. 1999).[19]

VII. THE COMPLAINT FAILS TO STATE ANY COGNIZABLE ERISA CLAIM

Plaintiffs also rehash their RICO allegations under ERISA, claiming that Aetna breached its statutory duties to Plaintiffs by failing to disclose how Aetna implements the cost-containment practices that characterize managed care. As Plaintiffs see it, a managed-care provider has "fiduciary" obligations under ERISA to disclose its physician compensation arrangements and other cost-containment practices to all of its members and potential members, regardless of circumstance. (Compl. ¶¶ 183-184, 189-99). Plaintiffs also creatively recast that same "nondisclosure" claim as a claim "for benefits" under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), on the theory that Aetna's undisclosed internal practices effectively deprived Plaintiffs of what they characterize as a "coverage-benefit" that is "distinct from individual claims for the payment of the medical losses incurred" by plan participants. (Compl. ¶ 204). Plaintiffs pray

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19 Because Plaintiffs' RICO claims would impair Texas's administrative regime and frustrate its declared state policies, this case is very different from that confronted by the Supreme Court in *Humana*, where the only potential conflict between Nevada's insurance law and RICO was the nature of the remedy provided. *See Humana*, 119 S. Ct. at 715 (considering whether "a federal law, which proscribes the same conduct as state law, but provides materially different remedies, 'impair[s]' state law under the McCarran-Ferguson Act"). The state laws implicated by Plaintiffs' RICO claims here do not merely regulate remedies for concededly wrongful conduct. Instead, they address the very core of state insurance regulation: what conduct by an insurer is (or is not) permissible and what rates are (or not) appropriate in light of the services rendered.

that those purported ERISA violations be remedied by injunctive relief and by "restitution" or a "*cy pres* trust" from which putative class members and their counsel will be compensated. (*Id.* at p. 94.)

* * * *

No. 01-10905

In The
United States Court of Appeals
For The Fifth Circuit

JUAN DAVILA,
Appellant

v.

AETNA U.S. HEALTHCARE; INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

BRIEF OF APPELLEES
AETNA U.S. HEALTHCARE INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

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[Page 4]

* * * *

Nevertheless, Davila purported to allege direct liability claims under the Act against Aetna arising from Aetna's purported refusal to fill a prescription recommended by Davila's treatment physician.[14]

[Page 16]

* * * *

. . . . authority from this and other circuits has applied it where (as here) a participant like Davila complains of an adverse utilization review determination. This Court and its sister circuits have recognized that prospective utilization review of medical benefits is an ERISA benefits determination.[41]

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14 1R2-3.

41 *See Thompson*, 202 F.3d at 1073 (upholding removal where precertification rejected for high dose chemotherapy and autologous bone marrow transplant); *Hull*, 188 F.3d at 941 (upholding removal where precertification rejected for thallium stress test); *Danca*, 185 F.3d at 3 (upholding removal where precertification rejected for inpatient psychiatric care); *Bast*, 150 F.3d at 1006 (finding preemption where precertification delayed for autologous bone marrow transplant); *Parrino*, 146 F.3d at 702 (upholding removal where "FHP initially refused to authorize payment for the therapy, claiming it was experimental and unnecessary"); *Turner*, 127 F.3d at 197 (upholding removal where "Transplant Committee . . . concluded . . . that the Duke program had as yet produced no adequate data suggesting a likelihood of success,"); *Jass*, 88 F.3d at 1485 (upholding removal where "Karen Margulis, an agent of PruCare, determined that [physical therapy] was not necessary"); *Cannon*, 77 F.3d at 1271 (upholding removal where "the insurers denied preauthorization for the ABMT); *Toltan*, 48 F.3d at 940 (finding preemption where plaintiff did not receive requested sub-

[Footnote continued on next page]

[Page 31]

Although Davila's Petition is intentionally vague on a great many things, it is clear on one matter: Davila is suing Aetna directly because of a decision that it made, not because of any "mixed eligibility and treatment determination" made by his treating physician. As such *Pegram* is particularly inapplicble, because "mixed eligibility ***and treatment*** determinations"[61] (which Davila continually disguises as "mixed medical decisions" or "mixed medical necessity determinations" or simply "mixed decisions")[62] are determinations made by ***treating physicians***, not independent claims administrators for ERISA plans.

* * * *

[Page 43]

First, the notion that one must resort to legislative history or law review pieces for a nearly 30-year-old federal statute with over 2800 opinions addressing preemption[84] is highly

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[Footnote continued from previous page]

stance abuse and psychiatric care); *Spain*, 11 F.3d at 131 (finding preemption where approval of autologous bone marrow transplant was delayed); *Kuhl*, 999 F.2d at 300 (upholding removal where "Lincoln National refused to precertify payment for the surgery"); *Rodriguez*, 980 F.2d at 1016 (upholding removal where "Rodriguez believed that the attention of an orthopedic specialist was needed, but was stymied in his efforts to obtain a referral letter from Heistand or Pacificare"); *Corcoran*, 965 F.2d at 1324-25 (upholding removal where "despite Dr. Collins's recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care").

61 *Pegram*, 530 U.S. at 231.

62 *See, e.g.*, App. Br. at 12, 13, 20, 30

84 *De Buono*, 520 U.S. at 809 n.1.

suspect. It is especially questionable in the area of benefits administration where Congress's intent is so clear. It is improper to muddy the legal waters with legislative history when the statutory command is clear. *United States v. Gonzales*, 520 U.S. 1, 6 (1997). Likewise, courts "have no authority to enforce [a] principl[e] gleaned solely from legislative history that has no statutory reference point." *Shannon v. United States*, 512 U.S. 573, 584 (1994).

U.S. COURT OF APPEALS FOR THE FIFTH CIRCUIT

Court of Appeals Docket #: 01-10891

RUBY R. CALAD AND WALTER PATRICK THORN,
Plaintiffs,

v.

CIGNA HEALTHCARE OF TEXAS, INC., ET AL.,
Defendants.

DOCKET ENTRIES

7/10/01 Private civil diversity case docketed. NOA filed by Appellant Ruby R Calad. [01-10891] (trm) [01-10891]

8/27/01 Record excerpts filed by Appellant Ruby R Calad in 01-10891 # of copies: 4 Sufficient [Y/N]: y. [01-10891, 01-10943] (rsm) [01-10891 01-10943]

8/27/01 Appellant's Brief filed by Appellant Ruby R Calad in 01-10891. Copies of brief: 7 # of pages: 55. Word count: 12,749 Disk Provided [Y/N]: Y Date of COS: 8/27/01 Sufficient [Y/N]: Y. [01-10891, 01-10943] A/Pet's Brief ddl satisfied. E/Res's Brief due on 9/26/01 for Cigna Healthcare TX in 01-10891. (sep) [01-10891 01-10943]

10/26/01 Record excerpts filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 # of copies: 7

Sufficient [Y/N]: y [01-10891, 01-10943] (sja) [01-10891 01-10943]

10/29/01 Appellee's Brief filed by Appellee Cigna Healthcare TX in 01-10891. Copies of Brief: 8 # of pages: 54. Word count: 12,751 Disk Provided [Y/N]: y Date of COS: 10/26/01 Sufficient [Y/N]: y. [01-10891, 01-10943] E/Res's Brief ddl satisfied. (sja) [01-10891 01-10943]

11/19/01 Cross Appellee's Brief filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant-Cross-Appellee Ruby R Calad in 01-10943. Copies of Brief: 7 # of pages: 26. Disk Provided [Y/N]: y Sufficient [Y/N]: N MISSING CERTIFICATE OF SERVICE, WRONG COLOR COVERS, MISSING SUMMARY OF ARGUMENT. [01-10891, 01-10943] XE/Res brief ddl satisfied. Sufficient Brief due on 12/3/01 for Ruby R Calad in 01-10891, for Ruby R Calad in 01-10943. (sja) [01-10891 01-109431

11/28/01 Appellee's Brief filed by Appellee Walter Patrick Thorn in 01-10943. Copies of Brief: 7 # of pages: 19. Disk Provided [Y/N]: y Date of COS: 11/26/01 Sufficient [Y/N]: y.[01-10943, 01-10891] E/Res's Brief ddl satisfied. (sja) [01-10891 01-109431

11/29/01 Letter referencing reply brief(s) filed as XE brief [3435442-1] by Appellant-Cross-Appellee Ruby R Calad in 01-10891, reply brief(s) filed as EX brief [3435442-1] by Appellant-Cross-Appellee Ruby R Calad in 01-10943, filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, in 01-10943. [3473504-1] [01-10891, 01-10943] (SEND TO SCR. JUDGE AND PANEL) (ksw) [01-10891 01-10943]

11/29/01 Brief made sufficient by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant-Cross-Appellee Ruby R Calad in 01-10943 [01-10891, 01-10943] Sufficient Brief ddl satisfied. Brief okay as filed. See letter filed 11/29/01.

12/11/01 Cross Appellant's Reply Brief filed by Appellee's-Cross-Appellant Aetna U.S. Hlthcare in 01-10891, Appellee-Cross-Appellant Aetn US Hlthcare N in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943, Copies of COS: 12/10/01 Sufficient [Y/N]: y. [01-10891, 01-10943] (sja) [01-10891 01-10943]

5/6/02 Oral argument heard. Case argued by George Parker Young for Appellant Robert Roark; Robert Roark, on behalf of the Estate of Gwen Roark in 01-10831, Robert N Eccles for Appellee Humana HMO Texas Inc, Appellee Humana Health Plan, Appellee Humana Inc in 01-10831, George Parker Young for Appellant-Cross-Appellee Ruby R Calad in 01-10891, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Robert N Eccles for Appellee Cigna Healthcare TX in 01-10891, George Parker Young for Appellant Juan Davila in 01-10905, John Bruce Shely for Appellee Aetna US Hlthcare of North Texas, Appellee Aetna US Hlthcare in 01-10905, George Parker Young for Appellee Walter Patrick Thorn, Appellant-Cross-Appellee Ruby R Calad in 01-10943, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US

Hlthcare in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (pft) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Opinion filed. Issd in T form? Y Issue Mandate due on 10/8/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943 . [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Judgment entered and filed. [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Costs taxed - Thorn pays 1/2 costs and defendants pay 1/2 costs. Copies to counsel. [3818848-1] [01-10891, 01-10943] (dtg) [01-10891 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 for rehearing. # of copies filed: 4 [3829883-1]. Issue Mandate ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant

Aetna US Hlthcare N in 01-10943 for rehearing en banc. # of copies filed: 20 [3830095-1] Sufficient Rehearing due on 10/11/02 for Aetna US Hlthcare N in 01-10891, for Aetna US Hlthcare in 01-10891, for Aetna US Hlthcare N in 01-10905, for Aetna US Hlthcare in 01-10905, for Aetna US Hlthcare N in 01-10943, for Aetna US Hlthcare in 01-10943. Sufficient [Y/N]: N Missing statement of facts. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/1/02 Petition filed by Appellee Cigna Healthcare TX in 01-10891 for rehearing en banc. # of copies filed: 20 [3831100-1]. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/2/02 Rehearing made sufficient by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 [01-10891, 01-10831, 01-10905, 01-10943] Sufficient Rehearing ddl satisfied. (mcs) [01-10831 01-10891 01-10905 01-10943]

10/4/02 Unopposed motion filed by Appellant Robert Roark in 01-10831 for leave to file rehearing out of time [3832947-1] Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (ksw) [01-10831 01-10891 01-10905 01-10943]

10/10/02 COURT Order filed granting the unopposed motion of appellant, Robert Roark, for leave to file

petition for rehearing en banc out of time [3832947-1] in 01-10831, 01-10891, 01-10905, 01-10943. (JES) Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

10/10/02 Petition filed by Appellant Robert Roark in 01-10831 for rehearing en banc. # of copies filed: 20 [3839307-1]. Submit Rehearing due ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

10/24/02 Response requested by the Court to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, Response/Opposition due on 11/4/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943. in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare,

Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc (3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (ksw) (01-10831 01-10891 01-10905 01-109431

11/4/02 Response/opposition filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant Juan Davila in 01-10905, Appellant-Cross-Appellee Ruby R Calad in 01-10943 to petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N Response/Opposition ddl satisfied in 01-10831, petition for rehearing en banc

[3831100-1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcarena, Aetna US Hlthcare N in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N in 01-10943. Sufficient [Y/N]: Y. [4006462-1] [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

11/4/02 Response/opposition filed by Appellee Humana Inc in 01-10831, Appellee Humana Health Pln TX in 01-10831, Appellee Humana HMO Texas Inc in 01-10831 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical

Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y. [4006487-1] [01-10831, 01-10891, 01-10905, 01-109431 (mcs) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943. Sufficient [Y/N]: Y [4006523-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

11/5/02 Response/opposition filed by Appellee Cigna Healthcare TX in 01-10891 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing

en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N1: Y [4006951-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas, Inc's petition for rehearing [3829883-1] in 01-10831, 01-10891, 01-10905, 01-10943, denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas Inc's petition for rehearing en banc [3830095-1] in 01-10831, 01-10891, 01-10905, 01-10943. With poll (Y/N)?: N. Issue Mandate due on 4/22/03 in 01-10831, in

	01-10891, in 01-10905, in 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-109431
4/15/03	COURT Order filed denying Robert Roark's petition for rehearing en banc [3839307-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943, denying Cigna Healthcare of Texas Incorporated's petition for rehearing en banc [3831100-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]
4/23/03	Mandate issued. Approved BOC Issued (Y/N)?: y [01-10831, 01-10891, 01-10905, 01-10943] Issue Mandate ddl satisfied. (wdc) [01-10831 01-10891 01-10905 01-109431

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS (DALLAS)

No. CIV. 3:00-cv-02693

RUBY R. CALAD AND WALTER PATRICK THORN,
Plaintiffs,

v.

CIGNA HEALTHCARE OF TEXAS, INC., ET AL.,
Defendants.

DOCKET ENTRIES

Filing Date	No.	Proceedings
12/11/2000	1	NOTICE OF REMOVAL(with state court papers attached); Filing Fee $150 Receipt # 134145 (15+) (lch) (Entered: 12/12/2000)
12/11/2000	1	DEMAND for jury trial made in state court by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn (15+) (lch) (Entered: 12/12/2000)
12/11/2000	2	ANSWER to Complaint by defendant Cigna Healthcare of (6) (lch) (Entered: 12/12/2000)
12/11/2000		PRELIMINARY ASSIGNMENT TO Magistrate Judge Jeff Kaplan (lch) (Entered: 12/12/2000)

Filing Date	No.	Proceedings
* * * * * *		
12/12/2000	4	Joinder and Consent to removal of civil action/RESPONSE by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT in support of [1-1] removal notice (3) (jrb) Modified on 12/14/2000 (Entered: 12/14/2000)
12/12/2000	5	CERTIFICATE OF INTERESTED PERSONS by defendant Cigna Healthcare of (3) (jrb) (Entered: 12/14/2000)
* * * * * *		
01/22/2001	8	MOTION by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to remand (9) (vdf) (Entered: 01/23/2001)
01/22/2001	9	BRIEF by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (vdf) (Entered: 01/23/2001)
01/23/2001	10	APPENDIX by plaintiff Ruby R. Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (vdf) (Entered: 01/23/2001)
* * * * * *		
02/20/2001	13	RESPONSE by defendant Cigna

Filing Date	No.	Proceedings
		Healthcare of in opposition to [8-1] motion to remand (4) (jrb) (Entered: 02/21/2001)
02/20/2001	14	MEMORANDUM by defendant Cigna Healthcare of in support of [13-1] opposition response (15+) (jrb) (Entered: 02/21/2001)
02/20/2001	15	APPENDIX by defendant Cigna Healthcare of in support of [13-1] opposition response (15+) (jrb) (Entered: 02/21/2001)
02/20/2001	16	MEMORANDUM by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT in support of [1-1] removal notice (15+) (jrb) (Entered: 02/21/2001)
* * * * * *		
03/09/2001	19	REPLY by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to response to [8-1] motion to remand. (Cigna) (10)1(jrb) Modified on 03/12/2001 (Entered: 03/12/2001)
03/09/2001	20	REPLY by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to response to [8-1] motion to remand. (Aetna) (11) (jrb) (Entered: 03/12/2001)
03/09/2001	21	Second APPENDIX by plaintiff

Filing Date	No.	Proceedings
		Ruby R Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (jrb) (Entered: 03/12/2001)
* * * * * *		
04/10/2001	28	Supplemental Appendix and RESPONSE by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn in opposition to [26-1] notice. (15+) (jrb) (Entered: 04/11/2001)
* * * * * *		
04/20/2001		Motion hearing re: [8-1] motion to remand Motion hearing held (cxj) (Entered: 04/23/2001)
04/20/2001	30	Minute order: Motion hearing Held before Senior Judge Barefoot Sanders Court Reporter: Janet Wright (1) (cxj) (Entered: 04/23/2001)
* * * * * *		
06/21/2001	33	MEMORANDUM OPINION AND ORDER. For the foregoing reasons, the Court concludes that Plaintiff Calad's claims were properly removed, and the Motion to Remand is therefore Denied with respect to Calad. As requested in the alternative by Calad, her claims against CIGNA are Dismissed With Prejudice. The

Filing Date	No.	Proceedings
		motion to Remand is Granted with respect to Plaintiff Thorn, and his claims are hereby Remanded to the 162nd. Judicial District Court of Dallas County, Texas. So Ordered. Granting in part, denying in part [8-1] motion to remand. See order for specifics. (Signed by Senior Judge Barefoot Sanders) Copies to counsel: 6/21/01 Page(s): 14 (tem) Modified on 06/21/2001 (Entered: 06/21/2001)
06/21/2001	34	JUDGMENT. It Is Ordered, Adjudged and Decreed by the Court that Plaintiff Calad's Motion to Remand is Denied. Pursuant to Plaintiff Calad's request, her claims are Dismissed with Prejudice. It Is Further Ordered, Adjudged and Decreed by the Court that Plaintiff Thorn's Motion to Remand is Granted, and his claims are Remanded to the 162nd. Judicial District Court of Dallas, County, Texas. (Signed by Senior Judge Barefoot Sanders) Copies to counsel: 6/21/01 Page(s): 1 (tem) (Entered: 06/21/2001)
06/21/2001		Case closed (tem) (Entered: 06/21/2001)
06/26/2001	35	CERTIFIED MAIL executed 6/22/01 [34-1] judgment order, [33-1] order received by the 162nd. Judi-

Filing Date	No.	Proceedings
		cial District Court, 600 Commerce Stree, Dallas, Tx (1) (tem) (Entered: 06/26/2001)
06/27/2001	36	NOTICE OF APPEAL by plaintiff Ruby R Calad re [34-1] judgment order Payment: NO FEE PAID TO Mailed (2) cc:Judge (jmr) Modified on 06/27/2001 (Entered: 06/27/2001)
06/27/2001		Notice of appeal and certified copy of docket to USCA: [36-1] appeal (jmr) (Entered: 06/27/2001)
07/06/2001		USCA appeal fees received $ 105.00 [36-1] appeal Receipt # 152584 (jmr) (Entered: 07/06/2001)
* * * * * *		
07/10/2001	38	NOTICE OF CROSS-APPEAL by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT Filing Fee $ 105.00 Receipt # 152717 TOOC (3) cc: Judge (jmr) Modified on 07/11/2001 (Entered: 07/11/2001)
07/11/2001		Notice of appeal and certified copy of docket to USCA: [38-1] cross appeal (jmr) (Entered: 07/11/2001)
07/12/2001		USCA Case Number, 01-10891 Re: [36-1] appeal USCA received NOA 7/2/01 (jmr) (Entered: 07/13/2001)

Filing Date	No.	Proceedings
* * * * * *		
07/25/2001		USCA Case Number, 01-10943 Re: [38-1] cross appeal USCA received NOA 7/12/01 (jmr) (Entered: 07/26/2001)
07/26/2001		Transmitted record on appeal 2 vol. record, 2 vol. USC, and 1 transcript to U.S. Court of Appeals: [36-1] appeal, [38-1] cross-appeal (jmr) Modified on 07/26/2001 (Entered: 07/26/2001)
04/25/2003	40	Revised Opinion of USCA. Judgment in 01-10831 (3:00cv2368-D), regarding the Roarks, is Affirmed. The judgment in No. 01-10891 (3:00cv2693-H) is REVERSED in regard to Calad and AFFIRMED IN REGARD to Thorn. The judgment in No. 01-10905 (4:00cv1855-Y) is REVERSED in regard to Davila. All these matters are REMANDED to the respective district courts for further proceedings, if any, that may be called for by this opinion in accordance with USCA judgment (certified copy) re [38] Notice of Appeal filed by Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare of North Texas, Inc., 36 Notice of Appeal filed by Ruby R Calad. (jmr) (Entered: 04/25/2003)

Filing Date	No.	Proceedings
04/25/2003	41	REVISED JUDGMENT/MANDATE of USCA Judgment of the District Court is affirmed in part and reversed in part, and the cause is remanded to the District Court for further proceedings in accordance with the opinion of this Court. Thorne pay 1/2 of the costs (on appeal) and defendants pay 1/2 of the costs (on appeal) as to [38] Notice of Appeal filed by Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare of North Texas, Inc., 36 Notice of Appeal filed by Ruby R Calad. Issued as Mandate: 4/23/03. (jmr) (Entered: 04/25/2003)
04/25/2003	42	BILL OF COSTS from USCA against Roarks (courtesy copy that came with order Docs. 40, 41) . (Entered: 04/25/2003)
* * * * * *		
04/28/2003	43	ORDER: This case is remanded to the 162nd Judicial District Court of Dallas County, Texas, for all further proceedings, in accordance with the Fifth Circuit Mandate. Certified copies of order mailed to all parties and to the District Court by certified mail, return receipt on 5/1/03. (Signed by Judge Barefoot Sanders on April 28, 2003) (jyg,) (Entered:

Filing Date	No.	Proceedings
		04/29/2003)
05/22/2003	44	Certified Mail Executed on May 21, 2003 re: 43 Order remanding to the 162nd Judicial District Court. (jyg,) (Entered: 05/28/2003)
* * * * * *		

CAUSE NO. 00-09041

RUBY R. CALAD AND WALTER PATRICK THORN, Plaintiffs, V. CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants.	IN THE DISTRICT COURT OF DALLAS COUNTY, TEXAS I-162ND JUDICIAL DISTRICT

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE STATE DISTRICT JUDGE:

NOW COMES PLAINTIFFS, Ruby R. Calad and Walter Patrick Thorn, filing this their Original Petition complaining of Cigna HealthCare of Texas, Inc. (d/b/a Healthsource) and Cigna Corporation (collectively "Cigna"); and AEtna U.S. Healthcare, Inc. and AEtna U.S. Healthcare of North Texas, Inc. (collectively "Aetna"), and or cause of action would show as follows:

I. DISCOVERY CONTROL PLAN

1. Discovery is intended to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

II. OVERVIEW

2. This claim is brought pursuant to, the Texas Health Care Liability Act, Tex. Civ. Prac. & Rem. Code §§ 88.001, et seq., complaining of Defendants' wrongful usurpation of

medical necessity determinations from Plaintiffs' treating physicians. In making its determinations as to the medical necessity of treatment recommended by Plaintiffs' own treating physicians. Defendants directly and adversely affected and influenced the quality of the medical diagnosis, care, and treatment provided to Plaintiffs, as more fully described herein.

A. Cigna's Negligent Adherence to its Medial Necessity Criteria Regarding Ruby Calad's Hospital Stay

3. On September 9, 1999, Ruby was admitted to Memorial City Hospital for a hysterectomy with rectal, bladder and vaginal repair. The surgery was to be performed by Cigna's physician, Dr. Estrada. At the time of her admission, Ruby was informed that for the scheduled major surgery, Cigna authorized only *one* day hospital stay as "medically necessary."

4. Despite undergoing this major surgery, Ms. Calad did not qualify under Cigna's medical necessity criteria for continued hospital stay and was unable to incur the expense personally. Despite the recommendations of her own treating physician, Ms. Calad was prematurely forced out of the hospital by Cigna while suffering intense pain treated with strong pain narcotics, unable to sit because of the episiotomy, while taking continuing medications for seizures, posttraumatic stress, unmanageable stress, panic disorder, depression, anxiety and attention deficit disorder. Ms. Calad continues to suffer the effects of this trauma.

B. AEtna's Negligent Delay of Walter Thorn's Medically Necessary Surgical Treatment

5. Walter Patrick Thorn was involved in an auto accident on September 9, 1999, in which he incurred numerous bodily injuries, including a severely injured left hand. His primary care physician, referred Mr. Thorn to an hand specialist, who

determined that Mr. Thom needed immediate surgery to save his hand, and scheduled Mr. Thorn to have surgery on his hand the next day.

6. Only hours before his scheduled surgery, however, AEtna withdrew its pre-approval of the surgery. As a result of this wrongful interference, Mr. Thorn's surgery was needlessly delayed for almost a week. The scarring Mr. Thorn incurred as a result of the delay in the surgery has resulted in reduced mobility of Mr. Thorn's hand.

7. AEtna's preemptive determination of the lack of medical necessity in promptly treating Walter Thorn, despite the recommendations his own treating physicians, directly and adversely affected and influenced the quality of care and treatment provided to Walter Thom, causing Anther injury to Walter Thorn's damaged hand, the effects of which he continues to suffer.

8. This suit is for damages caused by Defendants' wrongful usurption of medical necessity determinations from the Plaintiffs' treating physicians. The Defendants' preemptive determination of the lack of medical necessity in 1) refusing to allow Ms. Calad to stay longer in the hospital,, and 2) refusing to promptly treat Walter Thorn, despite the recommendations of their own treating physicians, directly and adversely affected and influenced the quality of cars and treatment provided to Plaintiffs, resulting in the injuries detailed herein.

III. PARTIES

A. Plaintiffs

9. Plaintiff Ruby R. Calad is an individual residing in Harris County, Texas.

10. Plaintiff Walter Patrick Thom is an individual residing in Palo Pinto County, Texas.

B. Defendants

11. Defendant CIGNA HEALTHCARE OF TEXAS, INC. d/b/a HEALTHSOURCE is a corporation organized under the laws of Texas to engage in the business of insurance. Said Defendant may be served through its designated agent for service of process, CT Corporation System, 350 N. St. Paul, Dallas, Texas 75201 with citation and a copy of this Petition attached thereto.

12. Defendant CIGNA CORPORATION, the parent corporation of Cigna HealthCare of Texas, Inc., is a foreign corporation (a Delaware corporation) that does not maintain a regular place of business or a designated agent for service of process in the State of Texas. Cigna Corporation, acting through its subsidiaries Cigna HealthCare of Texas, Inc. (d/b/a Healthsource) has sufficient contacts with the State of Texas so that, under the Texas Long Arm Statute, Tex, Civ. Prac. & Rem. Code §§ 17.041-17.045, this Court may properly exercise personal jurisdiction, and Cigna Corporation may be served with process by serving the Texas Secretary of State, comporting with due process requirements and without offending traditional notions of fair play and substantial justice. Cigna Corporation's last known home office address for service of process through the Secretary of the State of Texas is: One Liberty Place, 1650 Market Street, Philadelphia, Pennsylvania 19192-1550.

13. Defendant AETNA U.S. HEALTHCARE, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Suite 300, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

14. Defendant AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons

Freeway, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

IV. JURISDICTION AND VENUE

15. Jurisdiction is proper in this Court because the amount in controversy in this case exceeds the jurisdictional limits of State District Courts in Texas.

16. Venue is proper in Dallas County, Texas because both Cigna and AEtna maintain principal offices in Dallas County. See Tex. Civ. Prac. & Rem. Code § 15.002(a)(3).

V. FACTS

A. Cigna's Adverse Influence and Control Over Ruby Calad's Medically Necessary Hospitalization

17. Through her husband's employer, The Ryland Group. Inc. Ryland Homes, Plaintiff Ruby Calad and her husband selected the Cigna Exclusive Provider Program (EPP) medical plan for the coverage and provision of health care services Cigna's EPP plan—an insurance plan, not a self funded plan—is an in network only benefits program providing a national health maintenance organization (IMO) plat Subscribing to the EPP plan, Ruby and her husband chose to become members of Cigna HealthCare of Texas, Inc., a managed care organization which provides health care to individuals throughout Texas.

18. On September 9, 1999, Ruby was admitted to Memorial City Hospital for a hysterectomy with rectal, bladder and vaginal repair to be performed by Cigna's physician, William Joseph Estrada, M.D. Going through pre-authorization and coverage procedures with Cigna, Ruby was informed that for the scheduled major surgery, Cigna authorized only one day for her hospital stay. Dr. Estrada's nurse attempted to reassure Ruby that if the doctor felt Ruby needed to stay longer in the hospital she would stay longer.

19. Decisions regarding health care and discharge from inpatient facilities are not made by the physicians, however, but rather by a Cigna representative—usually a clerk or a nurse, not a licensed physician. It is Cigna which makes medical decisions and manages a patient's health care, and not so much the physicians within the Cigna HealthCare health plan. It was just such a Cigna hospital discharge nurse who insisted on Ruby's traumatic, premature discharge over the advice of Ruby's treating physician.

20. Despite the reassurances of Dr. Estrada's nurse, the stress of undergoing major surgery was compounded by Cigna's authorization, conveyed directly to Ruby, for no more than a single day hospital stay for recovery from the scheduled major surgery. Indeed, this stress and anxiety increased exponentially following the surgery when Ruby's physician, rather than being in charge of managing and coordinating her care, was informed by Cigna's nurse the second day after the major surgery that Ruby must leave the hospital if there was no hemorrhaging, fever, or high blood pressure—unless Ruby wanted to pay $1,500+ per day.

21. Not qualifying under Cigna's criteria for continued hospital stay and unable to incur the expense personally, Ruby suffered further pain and suffering when she was herded out of the hospital. Had Cigna deferred to and relied upon the advice and recommendation of Ruby's treating physician so that he was allowed to manage and coordinate her care, she would have remained in the hospital for additional time to recover from the major, traumatic surgery of the hysterectomy with rectal, bladder and vaginal repair. Instead, Ms. Calad endured needless pain and suffering which resulted in her returning to the hospital via the emergency room only a few days after Cigna's preemptive discharge. By reason of the above and foregoing, Ruby Calad comes now and sues.

B. AEtna's Adverse Influence and Control Over Walter Thorn's Medically Necessary Treatment

22. Plaintiff Walter Patrick Thorn is a resident of Gordon, Texas who receives his AEtna U.S. Healthcare through his employment as a coach for the Azle school district. On September 9, 1999, Mr. Thorn sustained numerous injuries in a car accident, and was flown by helicopter to Harris Methodist Fort Worth Hospital. At the time, the injury of greatest concern was that to his left hand which was severely injured and required the amputation of his ring-finger in the emergency room.

23. Two doctors at the hospital advised Mr. Thorn that another surgery would have to be performed within *two to three days* in order to save the remainder of his hand. The hospital remanded Mr. Thorn to his primary care provider, Dr. Singh, whom ha saw on September 14, 1999. Dr. Singh immediately referred Mr. Thorn to Dr. Harry Orenstein, a specialist and AEtna designated provider for the type of injury he sustained, whom he saw the same day. Dr. Orenstein recommended immediate surgery, and scheduled Mr. Thorn for surgery the next day.

24. On September 15,1999, mere bouts before the scheduled surgery and despite earlier indications that the surgery had been pre approved, AEtna refused to authorize Dr. Orenstein to perform the surgery. The insurer informed the specialist that AEtna would need to review the case before authorizing the surgery, despite the fact that time was of the essence in saving the hand.

25. Dr. Orenstein sent Mr. Thorn to a physical therapist for treatment so that the hand could be kept alive until the surgery was approved by AEtna. On September 21,1999; Mr. Thom's surgery was finally performed. However, the scarring incurred from the delay in the surgery has resulted in reduced mobility of Mr. Thorn's hand.

VI. CAUSE OF ACTION

A. Texas Health Care Liability Claim

26. Plaintiffs hereby incorporate Paragraphs 1 through 25 above, inclusive.

27. This claim is brought pursuant to §§ 88.001, et seq., of the Texas Civil Practices & Remedies Code. As described above, Defendants failed to use ordinary care in influencing, controlling, participating in and making medical necessity decisions regarding the medical treatment of Plaintiffs. Defendants each served as managed care entities exercising control and/or influence over the medical care received by Plaintiffs: By definition, a "managed care entity" includes any entity which delivers, administers, or assumes risk for health care services. See Tex, Civ. Prac. & Rem. Code, § 88.001(8).

28. Medical services were actually provided to Plaintiffs by the Defendants: they controlled, influenced, participated in, and made medical necessity decisions which affected the quality of the diagnosis care, and treatment provided to Plaintiffs, violating the duty of ordinary care set forth in §§ 88.001 and 88.002. Such violation of ordinary care was the proximate cause of Plaintiffs' damages, as described herein.

29. The Defendants, either singularly as the evidence may show, failed during the time in which they were influencing, controlling, participating in, or providing medical necessity decisions within the standard of care for Ruby Calad's need for continued hospitalization and the diagnosis, treatment and rehabilitation of Walter Thorn's injured hand. Additionally, these Defendants put systems in place such as to make such sub-standard care more likely than not.

30. Each and every one of the foregoing acts of omission and commission, taken separately and collectively, constituted the direct and proximate cause of injuries suffered by Plaintiffs. Accordingly, Plaintiffs bring suit for their damages pursuant to §§ 88.001, et seq., of the Tex. Civ. Prac. & Rem. Code. All such actions and inactions by the Defendants with regard to the medical necessity determinations made by Defendants with respect to Plaintiffs' care constitutes negli-

gence that has been the proximate cause of significant damages to Plaintiffs herein.

31. Plaintiffs have fulfilled all requirements of §§ 88.001, et seq., which are prerequisites to this suit Expert reports shall be filed within ninety (90) days of filing of this claim, as required by Tex Civ. Prac. & Rem. Code § 88.002(k). The independent review set forth in § 88.003 was of no benefit prior to filing this suit and is of no benefit now—the harm has already occurred.

VII. DAMAGES

32. Plaintiffs hereby incorporate Paragraphs 1 through 31 above, inclusive.

33. The foregoing acts and omissions, taken separately and collectively, were the direct and proximate cause of the harm caused to Plaintiffs. According Plaintiffs sue for.

Lost earnings, both past and future

Pecuniary loss, both past and future

Physical pain and mental anguish, both past and future

34. Plaintiffs' claims do not seek reimbursement for treatment, medical procedures, or hospitalization; Plaintiffs do not seek to recover for denial of any benefits. Notably, Plaintiffs' injuries cannot be remedied by any retroactive authorization or payment of any benefit. Plaintiffs seek relief based upon the Defendants' failure to use ordinary care in "influencing," "controlling," "participating in," and making medical necessity determinations, where care was actually being provided.

VIII. GROSS NEGLIGENCE/PUNITIVE DAMAGES

35. Plaintiffs hereby incorporate Paragraphs 1 through 35 above, inclusive.

36. Plaintiffs were the victims of a knowing, calculated scheme whereby the Defendants increased their profits by

adversely affecting the medical care for patients such as Ruby Calad and Walter Thom through the Defendants' own decisions regarding medical necessity. The evidence will show that Defendants had both actual and subjective knowledge that their scheme involved a degree of risk which would lead to the serious injury or death of Defendants' members such as Plaintiffs. Nonetheless, Defendants put in place and enforced their system of health care delivery, with conscious indifference to the rights, safety and welfare of others and the injury such a system which would cause. Therefore, Plaintiffs seek punitive damages, pursuant to § 41.001, *et seq.*, of the Texas Civil Practices & Remedies Code, against Defendants.

IX. PLAINTIFF'S CLAIMS FOR DAMAGES NOT BARRED BY ART. 4590i, §§ 11.02-11.04. or CPRC § 41.008

37. Plaintiffs' health care liability claims for damages against Defendants are not barred or limited by the Texas Medical Liability and Insurance Improvement Act, Tex Rev. Civ. Stat Ann. Art. 45901, §§ 11.02, 11.03, and 11.04 (Vernon Supp. 1995)("the Act"), which attempt to limit the maximum liability of physicians and certain health care providers, for medical or health care negligence in malpractice or health care liability claims only for the reasons that:

(a) Sections 11.02(a), 11.03, and 11.04 are arbitrary, unreasonable, and in violation of plaintiffs' rights to due process of law and/or equal protection of the laws under the Fifth and Fourteenth Amendments to the United States Constitution, and Article I, sections 3 and 19 of the Texas Constitution, because (1) the damage limitation invidiously discriminates between seriously injured or death victims of medical or health care negligence or malpractice. (2) the damage limitation grants health care providers special immunity from damages over other tort-feasors, (3) the damage limitation fails to provide a reasonable substitute for

malpractice victims or their heirs who suffer damages in excess of that amount, (4) the damage limitation discriminates between medical malpractice victims and victims of other torts in general, (5) article 4590i and/or the damage limitation did not have a rational basis or was not justified in view of the absence of a so called "medical malpractice crisis" or "medical malpractice insurance crisis," and (6) alternatively, the alleged crisis no longer exists;

(b) Sections 11.02, 11.03, and 11.04 are in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988);

(c) Sections 11.02, 11.03 and 11.04 are in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages;

(d) Sections 11.02, 11.03, and 11.04 unduly and unnecessarily restrict the plaintiffs' right to deal with the so-called "crisis" in violation of Tex. Rev. Civ. Stat Ann. Art. 4590i, section 1.02(b) & (c); and

(e) Sections 11.02, 11.03, and 11.04 were declared unconstitutional by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988). They are thus dead statutes because they can only be in force and effect if they are passed again, in a constitutional form, by the Texas Legislature. These statutes cannot be "resurrected" by the courts. Thus, sections 11.02, 11.03, and 11.04 are not in force and effect, and do not operate to limit the plaintiffs' damages.

(f) In the alternative, the Defendants are not "providers" under the Act.

(g) In the further alternative, the caps imposed by §§ 11.02, 11.03, and 11.04 apply on a per defendant basis.

38. Further, plaintiffs' claims for exemplary damages against Defendants arc not barred or limited by Texas Civil Practices & Remedies Code § 41.008, which attempts to limit the liability of Defendants for exemplary damages, for the reasons that:

(a) Section 41.008 is in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); and

(b) Section 41.008 is in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article 1, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages.

(c) In the alternative, the caps imposed by § 41.008 apply on a per defendant basis.

X. PREJUDGMENT INTEREST

39. The Plaintiffs also seek prejudgment interest as a matter of law on their damages described herein calculated in accordance with Tex. Rev. Civ. Stat., art. 5069-1.05, or upon such other terms, conditions, and rates as allowed by law.

40. Plaintiffs further request the Court to take judicial notice of the rate of interest published by the Texas Consumer Credit Commission in the Texas Register on the date of judgment in this cause for purposes of calculating the rate of prejudgment interest to be awarded to Plaintiffs in this cause, or such other periods of time, and such other rate or rates of

interest allowed by law for determination of prejudgment interest.

X. DEMAND FOR JURY TRIAL

41. Plaintiffs hereby demands a jury trial of the above entitled and numbered cause. The Plaintiffs are entitled to a trial by jury in the above cause pursuant to the Texas Constitution, Art. I, Section !5, and Tex. R. Civ. P. 216.

42. Plaintiffs sue Defendants jointly and severally.

XII. PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiffs Ruby Calad and Walter Patrick Thom pray that they have judgment against all Defendants named herein, as follows:

(a) That Plaintiffs recover judgment from Defendants for Plaintiffs' actual damages; in a total sum in excess of the jurisdictional limits of this court;

(b) That Plaintiffs recover judgment from the Defendants for exemplary damages, in a total sum in excess of the jurisdictional limits of this court;

(c) That Plaintiffs recover prejudgment interest on the amount accrued on the damage amount(s) at the highest legal rate allowed by law;

(d) That Plaintiffs recover post-judgment interest on the due amount at the highest legal rate from the date of judgment until it is paid;

(e) That Plaintiffs recover all costs of court;

(f) For such other and further relief, at law or in equity, to which they may, show themselves justly entitled.

Respectfully submitted,

__/s/ George Parker Young__

George Parker Young

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ATTORNEYS FOR PLAINTIFFS

IN THE U.S. DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN,	§	
	§	
v.		
	§	CIVIL ACTION NO.
CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE,	§	
CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	3-00CV-2693H
	§	

NOTICE OF REMOVAL

Defendants CIGNA HealthCare of Texas, Inc., d/b/a Healthsource, Cigna Corporation (herein after referred to collectively as CIGNA), file the following Notice of Removal ("Notice").

1. An action was commenced against CIGNA in the 162nd judicial district court of Dallas County, Texas. The action is entitled *Ruby R. Calad and Walter Patrick Thorn, Plaintiffs v. CIGNA Healthcare of Texas, Inc. d/b/a Healthsource, Cigna Corporation, Aetna U.S. Healthcare, Inc.; and Aetna U.S. Healthcare of North Texas, Inc., Defendants*, Cause No. 00-09041, (hereinafter "State Court Action"). The following process, pleadings and orders have been served on CIGNA or have been filed by CIGNA and are attached hereto as exhibits:

A. Plaintiffs' Original Petition

B. Original Answer of AETNA's U.S. Healthcare, Inc. and AETNA U.S. Healthcare of North Texas, Inc.

C. Judge's Docket Sheet

D. Return of citation of CIGNA Healthcare of TX, Inc. d/b/a Healthsource

E. Return of Citation of CIGNA Corporation

F. Return of Citation of Aetna U.S. Healthcare, Inc.

G. Return of Citation of Aetna U.S. Healthcare of N. Texas, Inc.

H. Letters

I. Certified copy of Docket Sheet

2. This Notice is timely brought. Pursuant to 28 U.S.C. 1446(b), this Notice is being filed within 30 days after receipt of the initial pleading (Plaintiff's Original Petition Ex. A) setting forth the Plaintiff's claims.

3. Removal venue is appropriate because the Dallas Division of the Northern District of Texas embraces the place where the State Court Action is pending.

4. Removal is appropriate because plaintiff's state-law claims are all completely preempted by ERISA. Regardless of how artfully plead are the claims, this is nothing more than a "denial of benefits" case. As shown below, Plaintiff's Original Petition focuses on CIGNA's alleged failure to authorize non-covered additional hospital days:[1]

---

[1] A plaintiff's pleadings control whether removal is appropriate. *See Brown v. Southwestern Bell Telephone Co.*, 901 F.2d 1250, 1254 (5th Cir. 1990). Plaintiff cannot defeat federal jurisdiction after removal by attempting to change his allegations or re-characterize his claims. *See Lynch Ford, Inc. v. Ford Motor Co.*, 934 F. Supp. 1005, 1007 (N.D. Ill 1996); *Xactron Management*

[Footnote continued on next page]

1). Ms. Calad did not qualify under CIGNA's medical necessity criteria for continued hospital stay and was unable to incur the expense personally. Petition Paragraph 4.

2). Going through preauthorization and coverage procedures with CIGNA, Ruby [Calad] was informed that for the scheduled major surgery, Cigna authorized only one day for her hospital stay. Petition Paragraph 18.

3). Ruby [Calad] did [n]ot [qualify] under CIGNA's criteria for continued hospital stay. Petition Paragraph 21

ERISA provides the *exclusive* remedy for resolution of claims like these.[2]

[Footnote continued from previous page]

Ltd. v. Kreepy Krauley USA, Inc., 697 F. Supp. 1465, 1466 (D. Fla. 1988).

[2] *See* 29 U.S.C. 1001 *et seq.* (§§ 501, 502); *also see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (wrongful denial of benefit payments).

6. Thus, Plaintiff's claims are completely preempted by ERISA and are removable to Federal Court under 28 USC § 1441 as an action arising under Federal law, even though the ERISA-related nature of the action does not appear from the face of the pleading.[3] Therefore, this Court has federal question jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. §§ 1001 *et seq.*

7. As an action of a civil nature found on a claim or right arising under the laws of the United States, this action is removable pursuant to the provisions of 28 U.S.C. 1441(a) and (b).

8. CIGNA has obtained the consent of all co-defendants.

9. Contemporaneous with the filing of this Notice, CIGNA has given the 162nd Judicial District Court of Dallas County, Texas, written notice of the same, a copy of which is attached hereto as Exhibit J.

WHEREFORE, Defendants CIGNA Healthcare of Texas, Inc. d/b/a Healthsource and Cigna Corporation respectfully remove this action to this Court.

Respectfully submitted,

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER

---

[3] *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

By: /s/ Steven R. Shaver
Steven R. Shaver
State Bar No. 18136550
5000 Renaissance Tower
1201 Elm Street
Dallas, Texas 75270
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(214) 698-1101 Facsimile

ATTORNEYS FOR DEFENDANTS CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTH-SOURCE, AND CIGNA CORPORATION

[Exhibits Omitted]

[Exhibit A in Appendix of Evidence Supporting Cigna's Response to Plaintiffs' Motion to Remand]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN, Plaintiffs, v. CIGNA HEALTHCARE OF TEXAS, INC, D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC.; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants.	CIVIL ACTION NO. 3:00-CV-2693-H

AFFIDAVIT OF JOHN W. WARGO

STATE OF MARYLAND

COUNTY OF MONTGOMERY

BEFORE ME, on this day, personally appeared John W. Wargo, who, after being duly sworn, deposed and stated as follows:

1. My name is John W. Wargo. I am over the age of twenty one years, have never been convicted of a felony, and am competent to make this affidavit.

2. I am employed by Connecticut General Life Insurance Company ("CGLIC") as the client manager for The Ry-

land Group, Inc. As such, I have personal knowledge of the facts set forth in this affidavit and all of the facts recited herein are true and correct.

3. The Ryland Group, Inc. maintains certain plans through which certain employment benefits, including but not limited to medical and dental benefits, are provided to eligible employees of The Ryland Group, Inc. My responsibilities as the client manager for The Ryland Group, Inc. have included oversight and management of certain benefit plans provided by The Ryland Group, Inc. pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). By virtue of my job responsibilities, I am familiar with the terms, conditions and operations of these benefit plans.

4. One of the benefit plans maintained by The Ryland Group, Inc. provides medical benefits to its eligible employees and their dependents. In 1999, the plan was called the Flexible Benefits Program of The Ryland Group, Inc. (the "Plan"). The Plan was and is maintained by The Ryland Group, Inc. for the purpose of providing for its participants or their beneficiaries medical, surgical and hospital care or benefits.

5. Upon establishing the Plan, The Ryland Group, Inc. prepared and issued to eligible employees a summary plan description which described the terms of and benefits provided under the Plan. A true and correct copy of the plan description is attached to my affidavit as Exhibit 1.

6. In 1999, CGLIC was a delegated administrative responsibilities for the Plan. CIGNA HealthCare of Texas, Inc. ("CIGNA HealthCare") is an affiliate of CGLIC. CIGNA HealthCare performed various administrative functions in connection with the Plan in Texas, including providing utilization review services. CIGNA HealthCare was also responsible for reviewing claims for benefits and making benefit determinations. Benefit payments under the Plan were

funded by The Ryland Group, Inc. Medical benefits coverage under the Plan was provided to employees and their dependents on a contributory basis. As such, employees who were enrolled for coverage under the Plan contributed to the cost of the Plan through individual payroll deductions. The Plan is an employee welfare benefit plan subject to ERISA.

7. At all times relevant to this lawsuit, Ruby Calad's spouse was employed by The Ryland Group, Inc. He and his wife, Ruby Calad, were covered under the Plan at the time of Ms. Calad's surgery in September 1999.

8. The documents attached to my affidavit are records of acts, events, conditions, or opinions, made at or near the time, by or from information transmitted by a person with knowledge of the acts, events or conditions. The documents are kept in the course of the regularly conducted business of CGLIC and/or CIGNA HealthCare and it is their regular business practice to make such records.

9. I have reviewed the above statements and they are true, complete and correct.

FURTHER AFFIANT SAYETH NOT.

/s/ John W. Wargo

John W. Wargo

SUBSCRIBED AND SWORN TO before me this 16th day of February, 2001.

SEAL

/s/ Carolyn Brown
Notary Public

[Exhibit 1 to Affidavit of John W. Wargo]

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When you select a participating provider, this plan pays a greater share of the costs than if you were to select a non-participating provider. Participating providers include physicians, hospitals and other health care professionals and facilities. Consult your Physician Guide for a list of participating providers in your area. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs.

Services Available In Conjunction With Your Medical Plan

The following several pages describe helpful services available in conjunction with your medical plan. You can access these services simply by calling the toll free number shown on the back of your ID card. These services are provided by Intracorp, a CIGNA Company and can help ensure that you and your covered Dependents benefit fully from your medical coverage.

For example;

- Through **CIGNA's toll free care line**, you can talk to a trained registered nurse who will help answer general benefit questions and will provide you with the names of participating providers in your area and in other cities should you require medical care while away from home.
- **Case Management** services help individuals with short term and catastrophic medical conditions by offering appropriate treatment options which meet the patient's needs and keep costs manageable.

You are encouraged to maximize the benefits under your medical plan by taking advantage of these important services.

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line is a medical advisory service provided through Intracorp., a CIGNA company. You can talk to a Registered Nurse (RN) during normal business

hours, Monday through Friday simply by calling the toll free number shown on your ID card. All calls are confidential. CIGNA's toll-free care line RNs can help answer general benefit questions, such as questions regarding pre-admission certification, and can provide assistance in locating physicians, hospitals and other health care services.

CIGNA's toll-free care line personnel can also provide you with the names of participating providers. If you or your dependents need medical care, you may consult your Physician Guide which lists the participating providers in your area or call CIGNA's toll-free number for assistance. And, if you or your dependents need medical care while away from home, you may have access to a national network of participating providers through CIGNA's Away From Home Care feature. Call CIGNA's toll-free care line for the names of participating providers in other network areas. Whether you obtain the name of a participating provider from your Physician Guide or through the care line, it is recommended that you call the provider to confirm that he or she is a current participant in the CIGNA Preferred Provider Program prior to making an appointment.

CIGNA's toll-free care line personnel cannot answer specific questions about your medical coverage or claims, provide medical opinions, comment on the competency or reputation of a provider, prescribe medication, give diagnoses or advice about treatment. You may be referred to an appropriate resource for questions related to these topics.

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management

arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up to date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the **toll free care fine number** shown on the back of your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

2. Intracorp assesses each case to determine whether Case Management is appropriate.

3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of an extended hospital convalescence.) You are not penalized it the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)

6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

IMPORTANT INFORMATION

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY THE RYLAND GROUP, INC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL. ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

THE SCHEDULE

MEDICAL BENEFITS—GENERAL

The Medical Benefits Plan offered by your Employer includes two options. These options are: (1) the Exclusive Provider Medical Benefits (Option I), and (2) the Comprehensive Medical Benefits (Option II).

You and your Dependents may enroll for only one of the options not for both options.

The sections of this certificate entitled "Exclusive Provider Medical Benefits" apply to coverage under Option I. The sections of this certificate entitled "Comprehensive Medical Benefits" apply to coverage under Option II. All other sections of the certificate apply to coverage under each of the options unless stated otherwise.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

To receive Exclusive Provider Medical Benefits, you and your Dependents must pay a portion of the expense for services and supplies. That portion is the Copayment. Refer to the Copayment section of The Schedule for more information.

Guest Privileges

If you or one of your Dependents will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for Exclusive Provider Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in

connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth. Please review this Plan for further details on the specific coverage available to you and your Dependents under this Plan.

Contract Year

Contract Year means a period from January 1st to December 31st in each calendar year.

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

Maximum Benefits	
For You and Your Dependents	**This Plan Will Pay;**
Lifetime Maximum Benefit	Unlimited
Inpatient Mental Illness Maximum	30 days per Contract Year
Inpatient Alcohol and Drug Abuse Maximum	30 days per Contract Year
External Prostheses Maximum	$1,000 per Contract Year
Skilled Nursing Facility Maximum	60 days per Contract Year
Outpatient Rehabilitative Therapy Maximum	60 consecutive days per condition
Daily Limits	
Hospital Bed and Board Daily Limit	The Hospital's negotiated daily rate
Skilled Nursing Facility Daily Limit	The Skilled Nursing Facility's negotiated daily rate
Hospice Bed and Board Daily Limit	The Hospice Facility's negotiated daily rate

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents
Copayments

The Emergency Service Copayment and the Provider Service Copayment are as follows:

Emergency Service/Copayment

The plan covers authorized Emergency Services. You and your Dependent pay the Emergency Care Copayment shown below. For information on Emergency Services, including any waiver provisions and restrictions refer to the section entitled "Exclusive Provider Medical Benefits."

Emergency Care Copayment for:

Physician's Office	$5 per visit
Emergency Room	$50 per visit

Provider Service Copayment

Office Visit	
Maternity	$0 for initial visit to confirm pregnancy only
Surgical Procedures	No Charge
Other (except for any services shown below)	$5 per visit
Infertility	
Office Visit for Diagnosis	$20 per visit
Surgery	$200 per surgery
Outpatient Rehabilitative Therapy	$5 per visit
Hospital Confinement for Mental Illness, Alcohol and Drug Abuse, (other than detoxification only)	$25 per day

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Provider Service Copayment (Cont.)

Outpatient Mental Illness (other than Group Therapy)	
First 20 Visits per Contract Year	$10 per visit
Visits 21-30 per Contract Year	$20 per visit
Outpatient Group Therapy for Mental Illness	$10 per visit
Outpatient Alcohol and Drug Abuse:	
First 20 Visits per Contract Year	$10 per visit
Visits 21-40 per Contract Year	$20 per visit
Visits 41-60 per Contract Year	$25 per visit

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents	This Plan Will Pay;
Lifetime Maximum Benefit	Unlimited
Maximum Benefits	
Inpatient Mental Illness Maximum (Calendar Year)	30 days
Inpatient Alcohol and Drug Abuse Maximum (Calendar Year)	30 days
Outpatient Mental Illness Maximum (Calendar Year)	30 visits $10 per visit for the first 20 visits. $20 per visit for the next 10 visits.
Outpatient Alcohol and Drug Abuse Maximum (Calendar Year)	60 visits, $10 per visit for the first 20 visits. $20 per visit for the next 20 visits. $25 per visit for the last 20 visits.
Home Health Care Maximum	40 visits per calendar year

COMPREHENSIVE MEDICAL BENEFITS (Cant.)

For You and Your Dependents	**This Plan Will Pay;**
Covered Expense Daily Limit	
Participating Provider Hospital	The Hospital's negotiated rate
Non Participating Provider Hospital	The Hospital's most common daily rate for a semiprivate room
Participating Provider Hospice Facility	The Hospice Facility's negotiated rate
Non Participating Provider Hospice Facility	The Hospice Facility's most common daily rate for a semiprivate room
Skilled Nursing Facility	The Skilled Nursing Facility's most common daily rate for a semiprivate room, for up to 60 days in a calendar year

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Deductibles

The Deductibles listed below are expenses to be paid by an Employee or a Department for the services rendered. These Deductibles are in addition to any other expenses incurred for which no benefits are payable because of any coinsurance factor.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and are not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Participating Provider Office Visit Copayment	$5, then the Plan pays 100%
First visit to confirm pregnancy	
Delivery charges (including subsequent prenatal and postnatal visits)	100%, subject to deductible
Immunizations, Allergy injections	$5 or the actual charge, whichever is less, then the Plan pays 100% of any balance
All other Office Visits	$5, then the Plan pays 100%*

*This copay is waived for mammography

Comprehensive Medical Deductibles (waived for Participating Provider expenses)	$1,000
Family Deductible	$3,000

After Comprehensive Medical Deductibles totaling $3,000 have been applied in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Comprehensive Medical Deductibles for the rest of that year.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Coat.)

For You and Your Dependents

Benefit Percentage

The Benefit Percentage for Covered Expenses incurred for charges made by a Participating or a Non Participating Provider is as follows.

	Participating Provider	Non Participating Provider
Outpatient Mental Illness, Alcohol and Drug Abuse	100%	50%
Emergency Services	100%	100%*
Well Child Care	100%	Not Covered
Well Woman Care	100%	Not Covered
Annual Routine Physical Exams (including immunizations)	100°io	Not Covered
Mammograms	100%	50 %, after the deductible
All Other Covered	100%	50%

*This is the same Benefit Percentage as for Participating Provider charges.

The Benefit Percentages above for Physician and professional services will be based on allowed charges.

Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth. Please review this Plan for further details on the specific coverage available to you and your Dependents under this Plan.

THE SCHEDULE

MEDICAL CARE BENEFITS

For You and Your Dependents

PAC/CSR REQUIREMENTS. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependents for each inpatient Hospital admission. CSR should be requested prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include:

- the first $300 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission;

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR;

- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

MEDICAL CARE BENEFITS
For You and Your Dependents

PAC/CSR REQUIREMENTS (Continued)

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

THE SCHEDULE

CIGNA TRADITIONAL DENTAL
For You and Your Dependents

HOW YOUR DENTAL PLAN WORKS

Class I Preventive Care	Plan pays 100% There is no Deductible	
Class II Basic Restorative	You or your Dependent pays $50 Deductible	Play pays 80%
Class III Major Restorative		Play pays 60%
Class IV Orthodontia		Play pays 50%
Class V TMJ		Play pays 60%

Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.

Maximum Benefit

Classes I, II, III Combined
Calendar Year Maximum $1,600

THE SCHEDULE

Class IV
Lifetime Maximum $1,500

Class V
Lifetime Maximum $750

Individual Deductible $50

A person must satisfy this deductible amount for each calendar year before Dental Benefits are payable.

Family Deductible $100

After Dental Deductibles totaling $100 have been applied in a calendar year for either (a) you and your Dependents; or (b) your Dependents; your family need not satisfy any further Dental Deductibles for the rest of that year.

SECTION 125 PLAN

Your Employer has agreed to provide benefits according to Section 125 of the Internal Revenue Code. A Section 125 plan is a written group Insurance plan which allows Employees a choice among two or more benefits consisting of salary (cash) and nontaxable benefits. Non-taxable benefits may be in the form of salary reduction. Therefore, normally taxable salary remains Employer money and is put toward benefits tax free.

Because your group insurance plan is a Section 125 plan, certain provisions of this certificate are superseded as described below.

No Longer in Active Service

If you return to Active Service within the same benefit plan year following your termination of employment. Section 125

plan provisions supersede the "Eligibility - Effective Date" section under the "Eligibility For Employee Insurance" provisions of your certificate as follows.

a. If your insurance ceases due to your termination of employment, your Employer may allow you to become insured again for your previously selected benefits upon your return to Active Service.

Termination of Insurance Due to Failure to Pay Premium

If you fail to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the "Eligibility Effective Date" section under the "Eligibility For Employee Insurance" provisions of your certificate as follows;

b. If your insurance ceases due to your failure to pay required premium, unless you are not in Active Service due to qualified leave of absence under the Family and Medical Leave Act of 1993, you will not be permitted to elect any coverage until the next Open Enrollment Period.

In addition, due to failure to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the "Eligibility Effective Date" section under the "Late Entrant Employee' provisions of your certificate as follows;

c. You may not enroll as a Late Entrant by providing evidence of good health, if your coverage terminates due to cancellation of your payroll deduction. You are not considered enrolled in the group insurance plan. You will not be able to select group insurance coverage until the next benefit plan year.

Change in Family Status

Due to a change in your family status, which changes your coverage needs, you may be eligible to change your benefits. Section 125 plan provisions supersede the "Eligibility Effective Date" section under the eligibility For Employee Insurance" provisions in your certificate as follows:

- You may be eligible to change your original selection of benefits when a change in your family status occurs. Consult your Employer for details.

SECTION 125 PLAN

Transfer Provisions

Section 125 plan provisions supersede the "Eligibility Effective Date" section under "For Dental Insurance—Employees Change in Option Elected" provisions as follows;

d. You may not transfer to another Option at any time prior to the next Open Enrollment Period.

Section 125 plan provisions supersede the "Important Information About Your Dental Plan" section under "Change in Option Elected in Addition to Open Enrollment" provisions as follows;

- You may not transfer to another Option at any time prior to the next Open Enrollment Period.

HOW TO FILE YOUR CLAIM

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required

will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card certifies that you are insured and tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical or Dental Expenses

The first Medical or Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS;

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER (2242852) WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

ELIGIBILITY EFFECTIVE DATE

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if

- you are in a Class of Eligible Employees; and
- you are an eligible, full time Employee; and
- you normally work at least 40 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of;

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: First day of the calendar month coinciding with or next following the Employee's date of hire.

New Employee Group: First day of the calendar month coinciding with or next following the Employee's date of hire

Classes of Eligible Employees

All Regularly Scheduled Full Time Employees

ELIGIBILITY—EFFECTIVE DATE

Employee Insurance

This Plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees in writing to insure you, provided that the effective date of your Medical Insurance will not be contingent upon evidence of good health. For plans which do not include a Pre existing Condition Limitation, you may be required to wait until the next plan enrollment period to elect coverage if you apply as a Late Entrant.

If you are not in Active Service on the date you would otherwise become insured, you will become insured on the date you return to Active Service.

Late Entrant Employee

You are a Late Entrant if;

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of good health at your expense it you are a Late Entrant. This Late Entrant provision will not apply to Medical Insurance.

ELIGIBILITY EFFECTIVE DATE

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the pay you become eligible for De-

pendent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees in writing to insure that Dependent, provided that the effective date of Medical Insurance will not be contingent upon evidence of good health. For plans which do not include a Preexisting Condition Limitation. You may be required to wait until the next plan enrollment period to elect coverage if you apply as a Late Entrant.

Your Dependents will be insured only if you are insured.

Late Entrant Dependent

You are a Late Entrant for Dependent Insurance if;

- you elect that insurance more than 30 days after you became eligible for it; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of your Dependent's good health at your expense if you are a Late Entrant. This Late Entrant provision will not apply to Medical Insurance.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth it you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for; (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child as soon as reasonably possible.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements;

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and

4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

When you elected Medical Insurance for yourself and your Dependents, you elected one of the two options provided by this Plan;

- Exclusive Provider Medical Benefits (Option I), or
- Comprehensive Medical Benefits (Option II)

Details of the benefits under each of the options are described in the following pages. Refer to the section entitled "Exclusive Provider Medical Benefits" or "Comprehensive Medical Benefits" depending on the option you elected.

When electing an option initially or when changing options as described below the following rules apply;

- You and your Dependents may enroll for only one of the options, not for both options.
- Your Dependents will be insured only if you are insured and only for the same option.

Changing Options

Change In Option Elected:

You may elect to change options for yourself and your Dependents during any Open Enrollment Period.

In addition, if you and your Dependents are insured under Option I, you may elect to transfer to Option II at any time if: 1) you relocate outside the Provider Organization's service area, or 2) you are deemed to be terminated for cause under Option I as determined by the Provider Organization.

Effective Date of Change In Option;

You are required to complete a new enrollment form for the option you elect. If you have done so, the effective date for the change in option is as follows:

If you are changing options during an Open Enrollment Period, you and your Dependents will become insured for the option elected on the first day of the month after the end of that Open Enrollment Period.

If you are transferring from Option I to Option II due to relocation or termination for cause, you and your Dependents will become insured for Option 11 on the date you relocate or are terminated.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

Effective Date of Change in Option: (Cont.)

However, if you are not in Active Service on the date you

and your Dependents would otherwise become insured for the option elected, the insurance under that option will become effective on the date you return to Active Service. (This provision will not apply in the case of a transfer to Option II due to termination for cause.)

You and your Dependents' insurance under the prior option will terminate on the same date that the insurance under the option elected is effective.

Open Enrollment Period

Open Enrollment Period means the period in each calendar year from October 1st to October 31st.

Primary Care Physician/Option I Only

Choice of Primary Care Physician;

When you elect insurance under Option I, you will select a Primary Care Physician for yourself and your Dependents from a list provided by the Provider Organization. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility;

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another through the Provider Organization. Any such transfer will be effective on the first day of the month following the month in which the Provider Organization completes

the processing of the change request.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.

DIRECT ACCESS FOR OB/GYN SERVICES:

Female insureds covered by this plan are allowed direct access to a licensed/certified participating practitioner for covered ob/gyn services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the participating practitioner of your choice for pregnancy, well woman gynecological exams, primacy and preventive gynecological care, and acute gynecological conditions.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses or any other expenses described below. CG wilt pay an amount determined as follows for the expenses so incurred after deducting the applicable Provider Service Copayment shown in The Schedule from the expenses incurred for the service received;

100% of the Covered Expenses incurred for charges for Emergency Services provided that; (a) the Emergency Services are received from or pre authorized by the person's Primary Care Physician; or (b) the Emergency Services are not so preauthorized, but are authorized by the Provider Organization after receipt of timely notice, within 48 hours of admission in the case of Hospital Confinement or as soon as reasonably possible. Before benefits are payable, the applicable Emergency Care Copayment shown in The Schedule will be deducted from such Covered Expenses, except that the Emergency Room Copayment

will be waived if the person becomes Confined in a Hospital due to that Injury or Sickness;

100% of any other Covered Expenses incurred for charges made by, or authorized care arranged by, a Participating Provider;

100% of the expenses incurred for vision and hearing screenings provided by the Primary Care Physician for persons age 17 and under;

100% of the expenses incurred for charges made by a Participating Provider for: (a) routine care of a newborn Dependent child prior to discharge from the Hospital nursery; (b) routine physical examinations; and (c) immunizations.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

No Exclusive Provider Medical Benefits are payable unless the services or supplies are recommended by and received from, or approved by, Participating Providers and are authorized by the person's Primary Care Physician and the Provider Organization, except in the case of Emergency Services as specified herein. In the case of mental illness, alcohol or drug abuse treatment, other than Hospital Confinement solely for detoxification, authorization by the Primary Care Physician will be waived.

Payment of benefits will be subject to the Maximum Benefit Provision and to the Mental Illness, Alcohol and Drug Abuse Maximums.

Maximum Benefit Provision

The total amount of benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

Mental Illness, Alcohol and Drug Abuse Maximums

The total number of days for which benefits are payable for

expenses incurred in any Contract Year while a person is Confined in a Hospital due to mental illness, alcohol or drug abuse will not exceed any Inpatient Maximums as shown in The Schedule for those causes. Hospital Confinement solely for detoxification does not count toward any such maximum.

The total number of visits for which benefits are payable for expenses incurred in any Contract Year due to mental illness, alcohol or drug abuse while a person is not Confined in a Hospital will not exceed any Outpatient Maximums as shown in The Schedule for those causes. Visits for treatment of mental illness which qualify as group therapy do not count toward any maximum number of visits shown in The Schedule for mental illness.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies: except that for any day of Hospital Confinement. Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.

- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

- charges made by a Free Standing Surgical Facility, on its own behalf for medical care and treatment.

- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Skilled Nursing Facility Limit shown in The Schedule; nor will benefits be payable far more than the maximum number of days shown in The Schedule.

- charges made by a facility licensed or certified to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.

- charges made by a facility licensed or certified to furnish treatment of alcohol and drug abuse on its own behalf for care and treatment provided on an outpatient basis.

- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

- charges made by a Home Health Care Agency for the following medical services and supplies, provided under the terms of a Home Health Care Plan for the person named in that plan;

- part time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

- part time or intermittent services of a Home Health Aide;

- physical occupational, or speech therapy;

- medical supplies; Durable Medical Equipment used by a person in the course of rendering covered home health care services; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility.

Covered Expenses do not include charges made by a Home Health Care Agency for;

- home health care visits in excess of any applicable Home Health Care Agency Limit shown in The Schedule (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit);

- care or treatment which is not stated in the Home Health Care Plan;

- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;

- a period when a person is not under the continuing care of a Physician.

- charges made for a person who has been diagnosed as having six months or fewer to live due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program;

- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room. Covered Expenses will not include that

portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;

- by a Hospice Facility for services provided on an out patient basis;

- by a Physician for professional services;

- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;

- for path relief treatment, including drugs, medicines and medical supplies;

- by a Home Health Care Agency for;

  - part time or intermittent nursing care by or under the supervision of a Nurse;

  - part time or intermittent services of a Home Health Aide;

  - physical, occupational and speech therapy;

  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses;

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;

- for any period when you or your Dependent is not under the care of a Physician;

- for services or supplies not listed in the Hospice Care Program;
- for any curative or life prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for expenses incurred;

- for or in connection with cosmetic surgery unless (a) a person receives an Injury, while insured for these benefits, which results in bodily damage requiring the Surgery; or (b) it qualifies as reconstructive surgery performed on a person following the surgery, and both the surgery and the reconstructive surgery are essential and medically necessary.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except as otherwise specified in this section. However, Covered Expenses will include the purchase of the first pair of contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or penodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an injury to sound natural teeth sustained while a person is insured for these benefits; or (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgi-

cal Facility or the outpatient department of a Hospital in connection with surgery.

- for transsexual surgery, including hormonal therapy.
- for routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court ordered, forensic or custodial evaluations.
- for which benefits are not payable according to the "General Limitations" section; except that the following will not apply to this section: (a) limitations with respect to a maximum for multiple surgical procedures, an allowable charge for an assistant surgeon or co-surgeon and covered providers being family members; (b) the limitation, if any, with respect to a Dependent child under 15 days old; and (c) any certification or second opinion requirements shown in The Schedule.

Covered Expenses will not include and no payment will be made for expenses incurred;

- for rehabilitative therapy by a licensed physical occupational or speech therapist on an outpatient bass, which is provided for any one condition more than 60 consecutive days after the date of the first such treatment for that condition;
- for charges made by a Physician for the diagnosis or outpatient treatment of structural imbalance, distortion or subluxanon of the vertebrae, except for outpatient rehabilitative therapy within 60 consecutive days per condition;
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation;

- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for penile prostheses;
- for organ procurement costs that are not directly related to procurement of an organ from a cadaver or a donor having a blood relationship with the recipient;
- for penile prostheses;
- for prescription drug charges incurred while not confined in a Hospital, except as noted in the Covered Expenses section;

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents

If, while insured for these benefits, you or any one of your Dependents incurs Covered Expenses. CG will pay an amount determined as follows;

> The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, after deducting any Comprehensive Medical Deductible shown in The Schedule from the Covered Expenses first incurred for a person in each calendar year.

Payment of any benefits will be subject to: (a) any applicable deductibles and maximum benefits shown in The Schedule; (b) the Maximum Benefit Provision; and (c) any Mental Illness, Alcohol and Drug Abuse Maximums.

COMPREHENSIVE MEDICAL BENEFITS

Full Payment Area -For Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $1,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $2,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred by a Participating Provider for or in connection with mental illness, alcohol or drug abuse will not be increased by the terms of this section.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible if not yet satisfied, will continue to apply until it is satisfied.

Full Payment Area - For Non Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $3,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a non Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $6,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a non-Participating Provider

during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred by a non-Participating Provider for or in connection with mental illness, alcohol or drug abuse will not be increased by the terms of this section.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied will continue to apply until it is satisfied.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by both Participating and non Participating Providers for which no payment is provided because of any Copayments, any Comprehensive Medical Deductible (including any benefit deductibles) and the coinsurance factor.

COMPREHENSIVE MEDICAL BENEFITS

Maximum Benefit Provision

The total amount of Comprehensive Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

Inpatient Mental Illness, Alcohol and Drug Abuse, Maximums (Calendar Year)

The total number of days for which benefits are payable for all expenses incurred in any calendar year while a person is Confined in a Hospital due to mental illness or due to alcohol or drug abuse will not exceed any separate Inpatient Maximums as shown in The Schedule for those causes.

Outpatient Mental Illness, Alcohol and Drug Abuse Maximums (Calendar Year)

The total number of visits for which benefits are payable or the maximum amount payable for ail expenses incurred in any calendar year due to mental illness or due to alcohol or

drug abuse while a person is not Confined in a Hospital will not exceed any separate Outpatient Maximums as shown in The Schedule for those causes.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.

- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

- charges made by a Free Standing Surgical Facility, on its own behalf, for medical care and treatment.

- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion which is more than the Skilled Nursing Facility Limit shown in The Schedule.

- charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.

- charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.

- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse for professional nursing service.

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational, or speech therapist; prosthetic appliances; dressings; and drugs and medicines lawfully dispensed only upon the written prescription of a Physician while a person is confined in a Hospital, excluding vitamins.

- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.

- charges made by a Participating Provider for visits for routine preventive (Well-Child) care of a Dependent child during the first tow years of that Dependant child's life, including immunizations.

- charges made by a Participating Provider for: (a) an annual routine physical examination and; (b) immunizations.

- charges made by a Participating Provider for an annual routine Well-Woman examination.

- charges made by a Physician for an annual routine mammogram.

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan;

    - part time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

    - part time or intermittent services of a Home Health Aide;

    - physical, occupational, or speech therapy;

    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for;

- home health care visits during a calendar year, in excess of the Home Health Care Maximum shown in The Schedule. (To determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);

- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made due to Terminal illness for the following Hospice Care Services provided under a Hospice Care Program;
- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
- by a Hospice Facility for services provided on an out patient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by a Home Health Care Agency for;

- part time or intermittent nursing care by or under the supervision of a Nurse;
- part time or intermittent services of a Home Health Aide;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses;

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

COMPREHENSIVE MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include and no payment will be made for, expenses incurred;

- for or in connection with cosmetic surgery unless; (a) while insured for these benefits, a person receives an injury, which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your Dependents who is less than 16 years old.

- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.

- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an Injury to sound natural teeth sustained while a person is insured for these benefits; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.

- for which benefits are not payable according to the "General Limitations" section; except that the limitations with respect to a maximum for multiple surgical procedures and an allowable charge for an assistant surgeon or cosurgeon will not apply to charges made by a Participating Provider.

COMPREHENSIVE MEDICAL BENEFITS

Common Accident

It you and one or more of your insured Dependents or it two or more of your insured Dependents are injured in the same accident and incur Covered Expenses for those injuries in the calendar year in which the accident occurs, not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred for them during the

rest of that calendar year.

Multiple Birth

Not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred in a calendar year for two or more of your Dependents born in a multiple birth if those Covered Expenses are incurred in the same calendar year in which they are born and are due to;

- premature birth;
- abnormal congenital condition; or
- injury which is received or Sickness which starts not more than 30 days after their birth.

DENTAL BENEFITS OPTION II

For You And Your Dependents

If you or any one of your Dependents incurs Covered Expenses, CG will

- deduct any Dental Deductible that applies from the Covered Expenses first incurred in a calendar year for a person; and
- pay for the other Covered Expenses incurred in that calendar year up to the Maximum Covered Expense determined from the Dental Services Schedule for each Dental Service subject to the Alternate Benefit Provision.

The Dental Deductible is shown in The Schedule.

Missing Teeth and Late Entrant Limit

The amount payable is 50% of the amount otherwise payable for a Class III or Class IV Dental Service in the case of a Late Entrant. No payment will be made for first replacement of teeth that are missing when a person becomes insured for these benefits.

If a person transfers from Option I directly to Option II,

credit will be given for the length of time he was insured under Option I.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Payments for Comprehensive Full Banded Orthodontic Treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3 month period. In determining the first installment, CG assigns 25% of the charge for the entire course of treatment to the appliance. The rest of such charge is prorated over the estimated duration of such treatment. These payments are made only for services performed while a person is insured.

If insurance or treatment on a person ceases during a period, the amount payable for that period will be prorated.

Maximum Benefit Provision

The total amount payable for all expenses incurred for other than Orthodontics for a person in a calendar year will not be more than the Maximum Benefit shown in The Schedule.

DENTAL BENEFITS OPTION II

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred for such charges when the Dental Service;

- is performed by or under the direction of a Dentist;

- is essential for the necessary care Of the teeth; and
- starts and is completed while the person is insured for Option II.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule is not included.

A Dental Service is deemed to start when the actual performance of the service starts except that;

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

If a person insured for Option II transfers directly to Option I after a Dental Service for fixed bridgework, full or partial dentures, a crown (inlay or onlay) or root canal therapy starts, but before it is completed, the benefits for that Dental Service when performed by the Dentist who started it will be provided under Option II until it is completed. No benefits will be provided for that Dental service under Option I.

Alternate Benefit Provision

When more than one Dental Service could provide suitable treatment based on common dental standards, CG will determine the Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed

Covered Expenses. For this reason, CG strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your dentist know in advance what the benefit plan will cover before any treatment begins.

DENTAL BENEFITS – OPTION II

Predetermination of Benefits

The term Predetermination of Benefits means a review by CG of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to CG before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CG.

The expenses that will be included as Covered Expenses will be determined by CG and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CG will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

DENTAL SERVICES SCHEDULE

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. CG may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to CG.

CG will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

A temporary Dental Service is included in the allowance for the final Dental Service and is not a separate Dental Service.

Dental Service

CLASS 1 SERVICES Diagnostic and Preventive

The Maximum Covered Expense for any Class I Service is 100% of the Reasonable and Customary Charge.

Clinical oral examination - Only two per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any X ray taken in connection with such treatment is a separate Dental Service.)

X-rays - Complete series - Only one per person, including Panoramic film, in any 3 calendar years.

Bitewing X-rays - Only two charges per person per calendar year.

Panoramic (Panorex) X-ray - Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) - Only two per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 19 years old. Only one per person per calendar year.

Topical application of sealant per tooth, on a posterior tooth for a person less than to years old. Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral Limited to non orthodontic treatment.

DENTAL SERVICES SCHEDULE

CLASS II SERVICES - Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

The Maximum Covered Expense for any Class II Service is 80 % of the Reasonable and Customary Charge.

Amalgam Filling - Primary (Baby) Teeth, One Surface

Amalgam Filling - Permanent Teeth, One Surface

Composite/Resin Filling, One Surface

Root Canal Therapy - Any X-ray test laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery - Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service.

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

Periodontal Scaling and Root Planing - Entire Mouth

Adjustments - Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not separate Dental Service.

Recement Bridge

Simple Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine post operative care for extractions and other oral surgery are part of the allowance for each Dental Service.

General Anesthesia - The administration of a general anesthetic is a Dental Service covered by this Schedule only: (a) when medically necessary in conjunction with oral or dental surgery; and (b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

DENTAL SERVICES SCHEDULE

CLASS III SERVICES Major Restorations Dentures and Bridgework

The Maximum Covered Expense for any Class III Service is 60% of the Reasonable and Customary Charge.

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive canes or fracture, cannot be restored with amalgam, composite/resin, silicate acrylic or plastic restoration.

Crowns

Porcelain Fused to High Noble Metal

Full Cast High Noble Metal

Three Fourths Cast, Metallic

Fixed or Removable Appliances

Complete (Full) Dentures, Upper or Lower Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps. rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

This Plan will permit a person who is eligible, but is not covered, under this Plan to be enrolled for its health care coverage when his health care coverage under another Plan ends if: (1) he is not eligible at that time for the other Plan, or a Plan which replaces it; and (2) his enrollment is made within 31 days after the later of: (a) the date his coverage under the other Plan ends; or (b) any continuation period elected by or for him under the other Plan ends.

If that person is enrolled for this Plan before the end of the 31 days, there will be no interruption of coverage. However, coverage under this Plan will be subject to the same requirements, except for postponement due to Active Service or Confinement that would have applied if he had been enrolled on the later of: (1) the date he was first eligible; or (2) the date he last became covered under this Plan. Credit will be given under any Preexisting Condition Limitation from the later of (1) or (2).

RIGHT OF REIMBURSEMENT

The Policy does not cover

(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the

Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG (or the Health-Plan) under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

PAYMENT OF BENEFITS

To Whom Payable

All Medical and Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

It any person to whom benefits are payable is a minor or, in the opinion of CG's not able to give a valid receipt for any payment due him. Such payment will be made to his legal guardian. If no request far payment has been made by his legal guardian. CG may, at its option make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives, spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Bridge Ponacs - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Abutment Crowns - Resin with High Noble Metal

Abutment Crowns - Porcelain Fused to High Noble Metal

Abutment Crowns - Full Cast High Noble Metal

CLASS IV SERVICES Orthodontics

The Maximum Covered Expense for any Class IV Service is 50% of the Reasonable and Customary Charge. Each month of active treatment is a separate Dental Service.

Orthodontic work up including X-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance

Active treatment per month after the first month

Fixed or Removable Appliances Only one appliance per person.

For Tooth Guidance - one arch per person

To Control Harmful Habits - one appliance per person

CLASS V SERVICES Temporomandibular Joint Dysfunction

The Maximum Covered Expense for any Class V Service is 60% of the Reasonable and Customary Charge. Only the Dental Services listed below will be considered covered expenses for the treatment of Temporomandibular Joint Dysfunction:

- Office Visit Adjustment to Appliance
- No more than 6 adjustments in 6 consecutive months after seating or placement of appliance.
- Transcutaneous Electro neural Stimulation

- No more than 4 treatments in a 6 month period.
- Trigger Point Injection of Local Anesthetic into Muscle Fascia
- No more than 4 treatments in a 6 month period.
- Mandibular Orthopedic Repositioning Appliance Only one appliance per person in any 5 year period.

DENTAL BENEFITS EXCLUSIONS

Services Not Covered

Covered Dental Services under Option I and Covered Expenses under Option II will not include and no payment will be made for:

- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a hospital;
- services performed solely for cosmetic reasons;
- any replacement of a bridge, crown or denture which is or can be made functional according to common dental standards;
- replacement of a lost or stolen appliance;
- services excluded according to the "General Limitations" section.

In addition, Dental Benefits under Option I and Option It will be reduced so that the total payment under the items below will not be more than 100% of the charge for the Dental Service if benefits are provided for that service under;

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by the Policyholder.

Covered Dental Services under Option I will not include or, where applicable, no payment will be made for;

- procedures, appliances or restorations whose main purpose is to: (a) change vertical dimension; or (b) diagnose or treat conditions or dysfunction of the temporomandlbular joint except as specified in the Patient Charge Schedule;
- prescription drugs; and sedation or a general anesthesia;
- procedures or appliances for minor tooth guidance;
- treatment rendered by a pedodontist on your Dependent child, who has reached seven years of age; however, an exception may be made due to medical reasons;
- replacement of fixed or removable prosthodontic appliances made useless due to patient abuse, misuse or neglect;
- any procedure or service associated with the placement or prosthodontic restoration of a dental implant.

DENTAL BENEFITS EXCLUSIONS

Services Not Covered

Covered Expenses under Option II will not include, and no payment will be made for. expenses incurred for;

- replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- procedures, appliances or restorations (except full dentures) whose main purpose is to; (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers on crowns or pontics on or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semi precision attachments; or splinting,
- a surgical implant of any type including any prosthetic device attached to it;
- instruction for plaque control oral hygiene and/or diet as separate services.

GENERAL LIMITATIONS
MEDICAL AND DENTAL BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents;

- for or in connection with an Injury arising out of, or in the course of any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;

- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled; "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
- to the extent of the exclusions imposed by any certification requirement or second opinion requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time; the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/ 2 of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the Surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase of replacement of contact lenses except as specifically provided under "Exclusive Provider Medical Benefits"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to Comply with;

- a "no fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

MEDICARE ELIGIBLES

The Medical and/or Dental Expense Insurance for:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 18 months;

will be modified where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under;

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated. All of the benefits from this plan are subject to Coordination of Benefits except those medical services authorized by the Provider Organization which are identified on a list available from the Provider Organization.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules determine its benefits after this Plan.

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated. **Coverage under this Plan plus another Plan will not guarantee 100% total reimbursement.**

The benefits that would be payable for a person from this Plan in the absence of Coordination of Benefits for expenses incurred in any Claim Determination Period will be reduced by the benefits payable for those expenses from all other Plans.

When the benefits from a Plan are in the form of services not cash payments the reasonable cash value of each service will be deemed to be a benefit paid. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would be based on its rules, determine its benefits after this Plan.

COORDINATION OF BENEFITS

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services; (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage

under any labor management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room are medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

COORDINATION OF BENEFITS

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom clam is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that; (a) if the other Plan does not have this rule its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(4) When the above rules do not establish the Order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that;

(a) The benefits of a Plan which covers the person as a laid off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid off or retired employee, or his dependent.

(b) It the other Plan does not have the rule in item (4)(a) which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

COORDINATION OF BENEFITS
Unrestricted Enrollment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to; (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

TERMINATION OF INSURANCE EMPLOYEES

Your insurance will cease on the earliest date below;

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month coinciding with or next following the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends due to temporary layoff or for more than 6 months past the date your Active Service ends if due to leave of absence.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness,

your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Medical Insurance)

If your Active Service ends because you retire, your medical insurance will be continued. If you are less than age 65 and insured under Option I on the date you retire, your insurance will be continued under Option I until you attain age 65. Your insurance will continue under Option II as of your 65th birthday. However, in no event will your insurance be continued past the date in which your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Dental Insurance)

If your Active Service ends because you retire, your dental insurance will be continued until the date in which your Employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance

with the rules of your Employers group health plans) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by CG for you and/or your Dependents, as applicable beyond the earliest of the following dates;

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your Dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to quality as a Dependent.

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date nonce of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates;

- 36 months from the date of (1), (2) or (3) above which ever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your De-

pendent would lose coverage because of an event described in (1), (2), or (3) of Section 8, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18 month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18 month continuation period as ether the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

To be eligible you or your Dependent must;

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following

the determination and within the initial 18 month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29 month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and 8 which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 16, 29 or 36 month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, or a period of time not to exceed the longer of; (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided;

- the required premium is paid; and

- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if;

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act

of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

MEDICAL BENEFITS EXTENSION

Any expense incurred within one year after a person's Medical Expense Insurance ceases will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if because of an Injury or a Sickness;

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness;

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

DENTAL BENEFITS EXTENSION

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if;

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.

- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.

- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

- for Orthodontic Services the treatment commenced while the person was insured and the expenses are incurred within 60 days after his insurance ceases.

There is no extension for any Dental Service not shown above.

SUMMARY PLAN DESCRIPTION

The name of the Plan is;

Flexible Benefits Program of The Ryland Group, Inc.

The Employer's address is;

11000 Broken Land Parkway, Columbia MD 21044

Employer Identification Number (EIN)	Plan Number
52-0849948	506

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA Healthplan, Inc.

The name, address, ZIP code and business telephone number of the Plan Administrator is;

The Ryland Group, Inc. 11000
Broken Land Parkway Columbia MD 21044

The name, address and ZIP code of the person designated as agent for the service of legal process is;

The Ryland Group, Inc. 11000
Broken Land Parkway Columbia MD 21044

Service of legal process may also be made upon a Plan Trustee (if any).

Plan Year

The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each twelve month period which ends on: October 9th.

SUMMARY PLAN DESCRIPTION

Statement of Rights

The following statement of ERISA rights is required by Federal law and regulations to be included in this Plan document;

As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. This law called ERISA, provides that all Plan Participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and Plan descriptions.

- obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator and asking for them. The Administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant under the Plan with a copy of this summary financial report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in the interest of other Plan Participants and beneficiaries.

The law provides that no one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you will receive a written notice, explaining why your claim was denied. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the documents and pay up to $100 a day until you receive them unless they were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may ask the U. S. Department of Labor for help, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. It you lose, the court may order you to pay these costs and fees, for example if it finds your claim frivolous.

If you have any questions about this statement or about your rights under ERISA, you should get in touch with the nearest Area Office of the U.S. Labor Management Services Administration of the Department of Labor.

If you have any questions about your Plan, you should see your Plan Administrator.

DEFINITIONS

Active Service

You will be considered in Active Service;

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a fulltime basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employers scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness. alcohol or drug abuse). Custodial Services include, but shall not be limited to;

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as; (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DEFINITIONS

Dependent

Dependents are;

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old.
  - 19 years but less than 25 years old, enrolled in school as a full time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25. Students as defined above, will also include those who perform Mormon missionary work.
  - 19 or more years old and primarily supported by you and incapable of self sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term child means a child born to you, adopted or in the process of adoption, and a stepchild, regardless of whether the stepchild lives with the Employee, if the Employee has a

legal obligation to support the child or any other child for whom the Employee is the legal guardian.

The term spouse also includes an individual who the Employee has lived with in a common law marriage for at least 2 years in a state where common law marriage is recognized.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

A dependent's insurance will cease at the end of the calendar month coinciding with or next following the date a dependent ceases to meet the definition of a Dependent, except that dependent children and students who reach the limiting age or graduate from college terminate at the end of the calendar year coinciding with or next following loss of eligibility.

DEFINITIONS

Durable Medical Equipment

The term Durable Medical Equipment means equipment which;

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Emergency Services

Emergency Services are medical, surgical, Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness which if not treated immediately, may result in serious medical com-

plications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Provider Organization, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

Employee

The term Employee means a full time employee of the Employer. The term does not include employees who are part-time or temporary or who normally work less than 40 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DEFINITIONS

Free Standing Surgical Facility

The term free standing Surgical Facility means an institution which meets all of the following requirements:

- It has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x ray facilities;
- it has equipment for emergency care;
- It has a blood supply;
- It maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and

- It is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a nonprofit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;

- is run according to rules established by a group of professional persons;

- maintains clinical records on all patients;

- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hos-

pital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

DEFINITIONS

Hospice Care Program

The term Hospice Care Program means:

- a coordinated interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;

- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;

- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;

- is accredited by the National Hospice Organization;

- meets standards established by CG; and

- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which; (a) maintains on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24 hour service by Registered Graduate Nurses;

- an institution which qualifies as a hospital a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or

- an institution which; (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DEFINITIONS

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is;

- a registered bed patient in a Hospital upon the recommendation of a Physician; or

- Partially Confined for treatment of; (a) mental illness; (b) alcohol or drug abuse; or (c) other related illness. To determine benefits payable, two days of being Partially Confined in a Hospital will be equal to one day of being confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24 hour period.

Injury

The term Injury means an accidental bodily injury.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N.," or "L.V.N."

DEFINITIONS

Participating Provider

The term Participating Provider means;

- an institution, facility, agency or health care professional which has contracted directly or indirectly with CG.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Employer.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider to general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

Provider Organization

The term Provider Organization refers to a network of Participating Providers.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is; (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is; (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DEFINITIONS

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if;

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and seventy of the Injury or Sickness being treated will be considered.

Sickness For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy Expenses incurred for routine Hospital

and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in;

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

[Exhibit B in Appendix of Evidence Supporting Cigna's Response to Plaintiffs' Motion to Remand]

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S-660: Hysterectomy, Vaginal, with or without Oophorectomy
CPT-4: 58145, 58260, 58262, 58263, 58267, 58270, 58275, 58280
ICD-9: 68.59
ICD-9: 218.X, 219.X, 221.0, 221.1, 618A

Case Management: Coordinate Care & Anticipate Needs

Preoperative: Hysterectomy is the most common major surgical procedure among women during their reproductive lives. Other options for menorrhagia include medical therapy, endometrial resection, and endometrial ablation. Other options for myomata include medical therapy and myomectomy. The vaginal approach to hysterectomy produces fewer complications and faster recovery than the abdominal approach. The majority of benign enlarged uteri can be resected vaginally, sometimes utilizing morcellation. Laparoscopic assistance is generally unnecessary.

Ensures patient education about postoperative pain management and recognition of postoperative complications. Assesses home safety, needs, and capabilities.

Day of Surgery: Ensures adequate recovery from anesthesia and pain control for discharge. Coordinates multiple caregivers as appropriate.

Home: May require home nursing contact for failure of oral pain control, reinforcement of education, or skilled assessment of complications or comorbidities.

Discharge Status Following Medical Care

Acute: Discharge on day 2; afebrile; bowel sounds present; passing flatus; diet as tolerated; pain control with oral or parenteral analgesic; postoperative nursing visits may be advantageous if oral hydration and nutrition have been marginal; bowel functions has been slow to return; or if the patient has difficulty with ambulation.

Home Care Treatment Plan

V-RN-1 Initial visit on the day of discharge or the next day to:

A. provide clinical assessment including hemodynamic stability, vaginal drainage, and bladder function

B. provide superficial wound care and observe for signs of infection

C. assess medication compliance/need/ knowledge

1. pain control by oral or parenteral analgesics (*See Home Pain Management Guidelines*)

2. evaluate that patient has all prescriptions as ordered, knows how to take them, and understands all common side effects

D. continue patient education

1. discuss limitations in lifting and gradual increase in activities

E. assess nutritional status

1. supplemental intravenous hydration and nutrition can be provided for one to two days

T/V-RN-2 Telephone followup or possible visit on the second or third day at home to:

A. assess pulmonary toilet and overall clinical status

B. provide superficial wound care

C. assess medication compliance/need/knowledge

D. continue patient education

E. assess and support nutritional status as needed

Discharge

Comfort level achieved; skin integrity maintained; tissue perfusion maintained; patient understands need to avoid prolonged sitting and heavy lifting.

IN THE U.S. DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN,	§	
Plaintiffs,	§	
v.	§	Case No.
	§	3-00CV-2693H
CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	
Defendants.	§	

PLAINTIFFS' REPLY TO CIGNA'S RESPONSE TO PLAINTIFFS' MOTION TO REMAND

* * * *

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. . . If this Court proceeds to deny Plaintiffs' Motion to Remand, it should also dismiss Ruby Calad's claims *sua sponte* in order to permit this matter to be immediately appealed since Ms. Calad will not be amending to add ERISA claims for benefits.

* * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

RUBY R. CALAD and WALTER PATRICK THORN,	§	
Plaintiffs,	§	Case No. 3-00-CV-2693 H
v.	§	Plaintiffs' Supplemental Appendix And Response to Aetna's Notices of new Preemption Authority
CIGNA HEALTHCARE OF TEXAS, INC. d/b/a/ HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC. and AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	
Defendants.	§	

PLAINTIFFS' SUPPLEMENTAL APPENDIX AND RESPONSE TO AETNA'S NOTICES OF NEW PREEMPTION AUTHORITY

* * * *

[EXHIBIT 2: Aetna Inc. and Aetna U.S. Healthcare Inc.'s Memorandum of Law in Opposition to Plaintiffs' Motion for Class Certification, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

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* * * *

The precise presentations made to health plan members about the scope of "medically necessary" care available to them vary considerably, and in ways that must be considered material under plaintiff's legal theory. (*See* Popik Decl. ¶¶ 26-31; *see also* Deposition of Julie G. Zyla ("Zyla Dep.") at 102-06.) Some derive from decisions made by individual employers with respect to the form and substance of disclosures; some derive from different CGLIC practices and disclosures from area to area and over time; and some derive from unique requirements of state law.[16]

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16 *See, e.g.*, Fla. Stat. § 409.913(1)(c) (2000) ("'Medical necessity' or 'medically necessary' means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain, or suffering, or results in illness or infirmity . . . provided in accordance with generally accepted standards of medical practice."); Ga. Code. Ann. § 33-20A-31(5) (2000) ("medically necessary care" is "care based upon generally accepted medical practice" that is (1) :[a]ppropriate and consistent with the diagnosis," (2) compatible with national "standards of acceptable medical practice," (3) "[p]rovided in a safe and appropriate setting," (4) "[n]ot provided solely for the convenience" of enrollee, provider or hospital, and (5) :[n]ot primarily custodial care"); La. Rev. Stat. § 22:657(D)(3)(e) (Supp. 2000) ("medically necessary" services are those "recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria"); Minn. Stat. § 62L.02 (subd. 21) (1999) ("'Medical necessity' means the appropriate and necessary medical

[Footnote continued on next page]

[EXHIBIT 3: CIGNA Corporation, CIGNA Health Corporation and Connecticut General Life Insurance Company's Memorandum of Law in Opposition to Plaintiff's Motion for Class Certification, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

* * * *

[Page 33]

State law is an important variable because HMOs and other managed care products are heavily regulated by the states, although the form of each state's regulation—*i.e.*, the types of disclosures it requires and the limitations it imposes—varies substantially. (*See* Wagener Decl. ¶ 3; Zyla Decl. ¶ 5 ("The applicable state law is also important in determining the information the member receives."); *see also* Zyla Dep. at 31).[18]

[Footnote continued from previous page]

and hospital services eligible for payment under a health benefit plan as determined by a health carrier."); N.C. Cent. Code § 26.1-04-03(17) (1999) ("Medically necessary" services are those that "a reasonably prudent physician or other health care provider would provide to a patient" that are (1) consistent with "generally accepted standards of medical practice," (2) "clinically appropriate," and (3) "not prohibited from establishing its own "definition of 'medically necessary care' for determining which services are covered by the health plan"); S.D. Admin. R. 20:06:21:08 (2000) ("When 'medically necessary' is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the . . . .

* * * *

18 The many variations in state disclosure laws mean that plaintiff's claim cannot be typical of those of putative class members from other states, and that common questions would not predominate. *Andrews*, 95 F.3d at 1025 (RICO claims unsuitable for class

[Footnote continued on next page]

* * * *

[Footnote continued from previous page]

action because problem with trying individualized elements of plaintiffs' claims . . . .

* * * *

[Excerpt from Record in CA5]

SUMMARY PLAN DESCRIPTION

The name of the Plan is:

Flexible Benefits Program of The Ryland Group, Inc.

The Employer's address is:

11000 Broken Land Parkway, Columbia, MD 21044

Employer Identification Number (EIN)	Plan Number
52-0849948	506

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA Healthplan, Inc.

The name, address, ZIP code and business telephone number of the Plan Administrator is:

The Ryland Group, Inc. 11000 Broken Land Parkway
Columbia, MD 21044

The name, address and ZIP code of the person designated as agent for the service of legal process is:

The Ryland Group, Inc. 11000 Broken Land Parkway
Columbia, MD 21044

Service of legal process may also be made upon a Plan Trustee (if any).

Plan Year

The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each twelve-month period which ends on:

October 9th

NO. 01-10891

In The United States Court of Appeals
For The Fifth Circuit

RUBY R. CALAD,
Plaintiff-Appellant-
Appellee,

and

WALTER PATRICK THORNE,
Plaintiff-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INC. d/b/a
Healthsource and CIGNA CORPORATION,
Defendant-Appellees,

and

AETNA U.S. HEALTHCARE, INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.
Defendant-Appellants.

Appeal From the United States District Court
for the Northern District of Texas, Dallas Division

BRIEF OF APPELLEES CIGNA HEALTHCARE OF TEXAS, INC. AND CIGNA CORPORATION

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October 26, 2001

[Page 3]

* * * *

Following the surgery, Calad did not meet the established criteria for extended hospitalization under her plan. 1R-7, 11-12. (Calad concedes that she "did not qualify under CIGNA's medical necessity criteria for continued hospital stay.") Although her treating doctor allegedly recommended that she remain hospitalized, Calad admits that she was unable or unwilling to pay for an extended hospital stay herself. 1R-7, 12. Accordingly, she was discharged from the hospital one day after her surgery. 1R-7, 11-12.

* * * *

[Page 6]

That CIGNA's benefit determination involved an evaluation of "medical necessity" in the administration of the plan does not remove Calad's claim from the scope of ERISA preemption.

* * * *

[Pages 22-23]

C. Under Well-Established Controlling Precedent, Calad's Claim in this Case Arises from a Benefit Determination

Despite her steadfast protestations that her claim is a purely state law claim which should not be preempted by ERISA, Calad's complaint stems entirely from a pre-surgery determination regarding the scope of benefits that would be provided to her under the plan. Calad's allegations against CIGNA include the following:

CIGNA "negligent[ly] adhered to its medical necessity criteria" by authorizing only one day of hospitalization as medically necessary following Calad's surgery (1R-7);

Calad "did not qualify under CIGNA's medical necessity criteria for continued hospital stay and was unable to incur the expense personally" and "[n]ot qualifying under [CIGNA]'s criteria for continued hospitalization," she was "unable to incur the expense personally" (1R-7, 12);

during "pre-authorization and coverage procedures," CIGNA authorized one day of hospitalization following surgery (R-11); and

CIGNA "put in place and enforced their system of health care delivery" in a manner which was consciously indifferent to her rights, safety and welfare (1R-15).

CIGNA made a determination regarding whether extended hospitalization was "medically necessary" following Calad's surgical procedure in its role as the administrator of an ERISA plan. The decision was based entirely upon the scope of benefits available to Calad under the plan according to plan criteria.

* * * *

[Page 39]

The "mixed treatment decision" in *Pegram* also presented a conundrum that is not present in this case. In *Pegram*, the doctor responsible for making medical treatment decisions was simultaneously responsible for making administrative determinations regarding the scope of coverage under the plan. Because the doctor wore two "hats," separating the treatment decision from the coverage determination was virtually impossible.

* * * *

[Page 53]

Finally, CIGNA does not argue that treatment decisions made by a treating doctor should be preempted by ERISA; clearly, they are not. But this case involves no treatment decision. In this regard, Calad's repeated assertion that the field of health care is a subject of traditional state regulation is irrelevant in this case. Calad has no complaint about the care she received from Dr. Estrada. Her complaint stems from her dissatisfaction with the determination made by CIGNA in its administration of the plan. Health care is a subject of state regulation; plan administration is governed by ERISA.

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(14)

No. 02-1845

Supreme Court, U.S.
FILED
DEC 18 2003
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

BRIEF FOR PETITIONER AETNA HEALTH INC.

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), as construed by this Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny, completely preempts state-law claims by ERISA plan participants or beneficiaries who assert that a managed care company tortiously "failed to cover" (*i.e.*, pay for) medical care.

PARTIES TO THE PROCEEDINGS

Petitioner Aetna Health Inc. is the successor to Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., both of which merged into Aetna Health Inc. In addition to the parties named in the caption, the following individuals and entities were parties in the consolidated cases below and are respondents in this Court. The following parties were defendants-appellees in the court below: Cigna Healthcare of Texas, Inc., d/b/a Cigna Corporation (petitioner in No. 03-83); Humana, Inc.; Humana Health Plan of Texas, Inc., d/b/a Humana Health Plan of Texas (Dallas), d/b/a Humana Health Plan of Texas (San Antonio), d/b/a Humana Health Plan of Texas (Corpus Christi); and Humana HMO Texas, Inc. The following party was a plaintiff-appellant-cross-appellee in the court below: Ruby R. Calad (named respondent in No. 03-83). The following parties were plaintiffs-appellants below: Robert Roark; and Robert Roark, on behalf of the estate of Gwen Roark. The following party was a plaintiff-cross-appellee in the court below: Walter Patrick Thorn.

RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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BRIEF FOR PETITIONER AETNA HEALTH INC.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-29a) is reported at 307 F.3d 298 (5th Cir. 2002). The opinion and order of the district court (Pet. App. 30a-35a) is unreported.

JURISDICTION

The district court had federal question jurisdiction over the plaintiff's claims pursuant to 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals had jurisdiction to review the final judgments of the district court pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on September 17, 2002. The court of appeals denied Aetna's petition for rehearing and suggestion for rehearing en banc on April 15, 2003. Pet. App. 37a-39a. The petition for a writ of certiorari was filed on June 20, 2003, and granted on November 3, 2003. 124 S. Ct. 462 (2003). This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. CONST. art. VI, cl. 2; Sections 502 and 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132 and 1144; and the Texas Health Care Liability Act ("THCLA"), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003, are set forth in the Petition Appendix at 41a-63a. Section 503 of ERISA, 29 U.S.C. § 1133, and the associated regulation, 29 C.F.R. § 2560.503-1, are set forth in the appendix to this brief.

STATEMENT OF THE CASE

Respondent Juan Davila, a participant in an employee health benefit plan insured by petitioner Aetna Health Inc. ("Aetna"), sued Aetna under Texas law for damages allegedly resulting from a medication that his doctor prescribed after Aetna, in accordance with the terms of the plan, determined that coverage was not available for a different medication. Aetna removed the action to federal district court, which concluded that Davila's state-law claims were completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). The court of appeals reversed, holding that Davila's claims were not preempted because they did not "duplicate" ERISA's remedial scheme.

1. ERISA's remedial scheme consists primarily of two statutory sections, ERISA §§ 502(a) and 503, 29 U.S.C. §§ 1132(a) and 1133. Section 503 and its implementing regulation (29 C.F.R. § 2560.503-1) require an ERISA plan to maintain elaborate procedures for beneficiaries to appeal adverse benefit determinations within the plan's administrative structure. If that internal appeal fails, Section 502(a) allows beneficiaries to go to court to ensure compliance with the terms of the plan and to obtain specified forms of relief—prospective and retrospective—for any failure to comply.

Under Section 502(a), a beneficiary may seek advance clarification of coverage before incurring the expense he wishes the benefit plan to cover. Alternatively, a beneficiary may seek relief after the fact by bringing an action for benefits due under the plan or for "appropriate equitable relief," together with a reasonable attorney's fee, but he cannot recover consequential or punitive damages. *See generally Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-53 (1987).

In *Pilot Life*, this Court held that Section 502(a)'s remedial scheme is exclusive and preempts any additional or supplemental state-law remedies for conduct governed by ERISA. 481 U.S. at 52. In *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), this Court held that any state-law claim that falls within Section 502(a)'s preemptive scope is removable to federal court because it necessarily states a federal question. *Id.* at 67.

2. Most Americans receive health coverage through employer-provided benefit plans, which are regulated by ERISA. Although ERISA subjects benefit plans to a uniform national regulatory framework, it also allows employers considerable flexibility in designing the type of health plan and the specific benefits they make available to their employees. *E.g.*, *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Employers generally use a competitive "request for proposals" ("RFP") process to select the plan's insurer (or, in the case of employers with self-funded plans, an insurance company that offers supportive administrative services). Insurance companies compete to provide these services, tailoring the details of their proposals to employers—from the scope of covered services to the rules for eligibility—to achieve the combination of costs and coverage that the particular employer desires. Even relatively simple changes in the scope of desired coverage can significantly change the cost, making the employer's expectation as to the scope of coverage, limitations, and exclusions particularly important in the bidding process. *See, e.g.*, David M. Studdert et al., *Expanded Managed Care Liability: What Impact on Employer Coverage*, HEALTH AFFAIRS, Nov./Dec. 1999, at 20.

A common model is the health maintenance organization (HMO), which carefully emphasizes preventive care and provides incentives or restrictions to participants to obtain care and services within a contracted network of health care providers.[1] This structure decreases the need to treat pre-

[1] In a "network model" HMO, such as Aetna's, the HMO itself does not provide medical care. Rather, the HMO contracts

ventable conditions, limits incentives to undergo unnecessary procedures, and improves predictability, allowing the employer to secure from insurers, such as Aetna, discounted prices in the RFP process.[2] In the principal alternative, a fee-for-service or full indemnity plan charges employers (and, thus, employee-beneficiaries whom the employers ask to contribute to defray the costs of health coverage) a considerably higher premium and in return generally offers a broader range of coverage with fewer exclusions and limitations and fewer or no provider network restrictions. *See generally* PAUL J. FELDSTEIN, HEALTH POLICY ISSUES 161-66

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with a network of treating physicians (often referred to as "participating providers") who agree to provide services to HMO members according to established fee schedules. Under the network model, the treating physician is independent of the HMO, and his treatment decisions are not bound by any coverage determination that the HMO may make for the purpose of deciding whether the employer's plan will pay for the proposed treatment. By contrast, physicians in a "group model" or "staff model" HMO make both coverage and treatment decisions. Group-model HMOs are owned or operated by physicians, and staff-model HMOs retain the physicians as salaried employees—rather than independent contractors—of the HMO. Thus, group- and staff-model HMOs provide medical care themselves. And the treating physicians are also responsible for making coverage determinations. *See, e.g.*, 1 BARRY R. FURROW ET AL., HEALTH LAW § 9-11, at 500 (2d ed. 2000); STEVEN J. SACHER ET AL., EMPLOYEE BENEFITS LAW 1076 & n.322 (2d ed. 2000); *see also Pegram v. Herdrich*, 530 U.S. 211, 216 n.3 (2000). Because the physicians provide care exclusively through the HMO (and *vice versa*), the treating physician may not be able to recommend treatment that the HMO cannot provide.

[2] Indeed, reducing unnecessary procedures may have the additional salutary effect of reducing the ensuing complications. *Pegram*, 530 U.S. at 221; *see, e.g.*, Ching-To Albert Ma & Michael H. Riordan, *Insurance, Moral Hazard, and Managed Care*, 11 J. ECON. & MGMT. STRATEGY 81 (2002).

(1994); 1 BARRY R. FURROW ET AL., HEALTH LAW § 9-10, at 505-06 (2d ed. 2000). Both HMOs and fee-for-service models use some form of managed care techniques to control health costs and keep premiums at predictable levels. When designing the health plan that they will offer their employees, employers may determine which managed care techniques to apply.

Managed care techniques take various forms, but the most common element is the process of prospective "utilization review," which controls costs by eliminating unnecessary expenditures and by carefully delimiting the scope of coverage to favor those procedures that are both necessary and cost-effective. Indeed, almost every form of employer-provided health plan now includes some element of utilization review. FELDSTEIN, *supra*, at 162-63.

Managed care strategies require the companies that perform utilization review for an employee health benefit plan to differentiate between covered and uncovered services each time a participant presents a claim for benefits (or, if required under the plan, requests precertification of coverage). Those companies make these decisions by interpreting the plan documents, which regulate the scope of coverage both through specific exclusions—such as a declaration that chiropractic care is never covered—and through a general contract term requiring that services be "medically necessary" in order to be covered. 1 FURROW, *supra*, § 9-2, at 473-74.[3] "Medical necessity" is a term of art that each plan document defines individually. Generally, such definitions incorporate

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[3] "[I]nsurance contracts do not have to contain such guarantees, and not all do. Some, for instance, guarantee medically necessary care, but then modify that obligation by excluding experimental procedures from coverage." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 380 n.10 (2002) (citing *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192 (8th Cir. 2002)).

economic considerations as well as medical ones: a "medically necessary" procedure or treatment often is defined as one that is not only medically appropriate, but also more cost-effective than any other, equally appropriate procedure or treatment. *E.g.*, J.A. 54-55. In the context of prescription drug coverage, which becomes prohibitively expensive without cost controls, employer plan sponsors seek RFPs that either exclude certain expensive drugs from coverage or pay for such drugs only after more economical alternatives fail, often through a detailed listing known as a "formulary." *See, e.g.*, Stephan L. Burton et al., *The Ethics of Pharmaceutical Benefit Management*, HEALTH AFFAIRS, Sept./Oct. 2001, at 150, 154.

3. Davila is employed by Monitronics International Inc., a burglar-alarm company. Pet. App. 67a. Monitronics is one of the many employers in Texas that contract with Aetna to insure and help administer its employee health benefit plan. In a Group Agreement effective December 1, 1999, Aetna contracted to provide insurance coverage for Monitronics employees participating in the company's health plan, which is an employee welfare benefit plan governed by ERISA. J.A. 25. Davila was a participant in the Monitronics Plan. *Id.* at 15.

Under the agreement, Aetna provides administrative services to the Monitronics Plan: it reviews requests for coverage and pays providers—*e.g.*, doctors, hospitals, nursing homes, pharmacists, and the like—who perform covered services for members. J.A. 34-35 ("[Aetna] has complete authority to review all claims for Covered Benefits .... [Aetna] shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage ...." (boldface omitted)). In this network-model HMO, Aetna does not itself provide any medical services; the professionals who provide services to plan members are "independent contractors," not Aetna em-

ployees, and it is those professionals who are "solely responsible for any health services rendered." *Id.* at 31.

The Monitronics Plan details the benefits to which participants and other beneficiaries may be entitled, and it specifies that Aetna will not approve benefits for any service that is not "Medically Necessary" as defined in the plan documents.[4] Under the plan, medical necessity includes both medical criteria and cost-based factors: in general, a "medically necessary" service is one that is both "as likely to produce a significant positive outcome as ... any alternative service or supply," and "no more costly ... than any equally effective service or supply." J.A. 54-55.

The plan documents reiterate that Aetna's coverage determinations do not control the treating physician's recommendation or prevent a beneficiary from following a prescribed course of treatment that does not meet the contractual definition of "medical necessity." The definition of medical necessity, the plan specifies, is only "[f]or the purpose of coverage." J.A. 54. Coverage denotes payment by the plan, and lack of coverage does not preclude a plan member from receiving a non-covered service through other means. To this end, the Monitronics Plan's Certificate of Coverage emphasizes in bold print: "**THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.**" *Id.* at 40; *see also id.* at 106-07, 108. The Moni-

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[4] The plan contains certain specific exceptions under which it expressly covers certain services, such as an annual mammogram, even when they are *not* medically necessary as defined by the plan. J.A. 58. The plan also excludes various expenses—such as blood plasma and experimental drugs—from the scope of coverage regardless of medical necessity. *Id.* at 70, 76.

tronics Plan also makes clear that "[i]f the Member's [treating physician] performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member's responsibility." *Id.* at 46 (boldface omitted).

A rider to the Monitronics Plan governs prescription drug coverage. The rider does not alter the definition of medical necessity, and further specifies that prescription drugs are covered only as "indicated . . . for a medical condition as determined by" Aetna. J.A. 141. Pursuant to the rider, Aetna maintains a formulary listing the terms under which prescription medications are covered. App., *infra*, 26a-40a.[5] Under the formulary, certain expensive medications are subject to precertification requirements (*i.e.*, coverage must be approved before the prescription can be filled at the insured rate) and/or a "step-therapy program" (*i.e.*, alternative, less expensive medications will be covered first unless they are contraindicated). *See id.* at 30a, 34a.

4. Davila consulted his physician, Dr. Joseph Lopez, for treatment of pain associated with arthritis. Dr. Lopez prescribed Vioxx, an anti-inflammatory medication, and sought precertification for the Vioxx prescription from Aetna. Pet. App. 77a.[6] In a letter to Dr. Lopez, an Aetna pharmacologist explained that Vioxx appears on the prescription drug formulary only conditionally. *Id.* at 80a-81a. Under the formulary's step-therapy program, Vioxx is a covered plan benefit

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[5] Although the formulary was cited in the complaint, it was not included in the certified record below. Davila does not oppose the inclusion of relevant excerpts in the appendix to this brief.

[6] Vioxx was then new to the market and the subject of massive marketing efforts. *See, e.g.*, Janice Rosenberg, *Head to head struggle: Initial Celebrex, Vioxx ad spending, sales stunning*, ADVERTISING AGE, Apr. 3, 2000, at S2.

only if the member has already tried—or cannot try, because of allergy or contraindication—at least two of the fifteen other, similar drugs that are listed unconditionally on the formulary. *Id.* at 80a; *see* App., *infra*, 29a-30a, 40a. The letter to Dr. Lopez also reminded him that Davila could submit a grievance to Aetna challenging the decision, or appeal Aetna's coverage determination to an Independent Review Organization (IRO). Pet. App. 81a. *See generally Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359, 361 (2002) (discussing state laws providing for IRO appeals). Either the internal grievance or the IRO appeal could have been expedited if Davila's condition had been life-threatening. Pet. App. 81a; J.A. 93, 94-95.

Davila's complaint reveals that he did not avail himself of *any* of the several options available to him if he or Dr. Lopez thought Vioxx was more appropriate than any of the fifteen alternative medications. He did not represent to Aetna that he had a "contraindication, intolerance, [or] allergy" that made it inadvisable to prescribe one or more of the Vioxx alternatives listed on Aetna's formulary. He did not file a grievance with Aetna or invoke his statutory right to an IRO appeal. And he did not file an action under ERISA § 502(a)(1)(B) to compel Aetna to pay for Vioxx under the Monitronics Plan. *See* Pet. App. 70a. Moreover, Davila chose not to pay to have the original Vioxx prescription filled while seeking coverage. Instead, Dr. Lopez prescribed Naprosyn—one of the fifteen anti-inflammatory medications listed on the formulary as less expensive alternatives to Vioxx—for Davila's arthritis. *See id.* at 68a; App., *infra*, 29a-30a, 40a. Several weeks later, Davila was hospitalized and diagnosed with bleeding ulcers. Pet. App. 68a.

Davila claimed that the ulcers were caused by the Naprosyn prescribed by Dr. Lopez and that they would not have occurred had he taken Vioxx instead. But he did not sue Dr. Lopez for malpractice for prescribing Naprosyn. In-

stead, he sued Aetna in Texas state court for following the plan formulary and declining to pay for Vioxx until Davila's physician had either tried another medication or determined that the covered alternatives were contraindicated by Davila's condition. Pet. App. 68a-69a. Davila's complaint asserted claims under the Texas Health Care Liability Act ("THCLA"), TEX. CIV. PRAC. & REM. CODE §§ 88.001-.003, a recently enacted state statute that purports to authorize suits against HMOs based on the medical treatment provided to their members. Davila demanded consequential and punitive damages and a jury trial. Pet. App. 70a-71a, 74a.

a. Aetna removed the action to the United States District Court for the Northern District of Texas, asserting that Davila's claims were completely preempted by ERISA as construed in *Pilot Life*, and thus were removable under *Metropolitan Life*. Pet. App. 89a. Davila asserted that subsequent decisions by this Court had undermined the complete preemption rule articulated in *Pilot Life* and *Metropolitan Life*, and he moved to remand based on lack of subject matter jurisdiction. The district court denied the motion, concluding that "[w]hat Plaintiff really challenges . . . is Defendants' determination regarding which particular drugs are covered under the plan and the circumstances of that coverage." *Id.* at 34a.[7] Therefore, Davila's claims "concern[ed] the administration of benefits under the plan." *Id.* Accordingly, under *Metropolitan Life*, Davila's claims had to be recharacterized as federal. *Id.* Because Davila expressly refused to proceed with a claim for benefits under ERISA, the district court then dismissed the action with prejudice. *Id.* at 34a-35a.

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[7] Although Davila's complaint contained a conclusory allegation that Aetna provided medical services (Pet. App. 69a), the district court determined from the plan documents, Dr. Lopez's affidavit, and Davila's own recitation of the facts that Davila's claims actually involved benefits administration. *See id.* at 34a.

b. On appeal, the Fifth Circuit consolidated Davila's case for argument with those of several other individuals who had sued HMOs under the THCLA, including Ruby Calad, the respondent in the consolidated case (No. 03-83). The court of appeals reversed the dismissal of both Davila's and Calad's actions. The court did not examine whether the state-law claims Davila and Calad asserted, or the remedies they sought, impermissibly *supplemented* the exclusive remedial scheme set out in Section 502(a). Instead, it confined its analysis to whether a THCLA claim precisely "duplicates" any provision of Section 502(a)—an inquiry that it answered in the negative. Pet. App. 9a, 10a-20a.

According to the court of appeals, Section 502(a)(3) could not preempt respondents' THCLA claims, because that provision allows "only those categories of remedies that were typically available in equity, *not the damages claims Calad and Davila bring*." Pet. App. 10a (emphasis added) (citation and internal quotation marks omitted). For similar reasons, the Fifth Circuit thought that Section 502(a)(1)(B) could not preempt the state-law causes of action: The THCLA claims, the Fifth Circuit wrote, were more in the nature of actions in tort, whereas Section 502(a)(1)(B) is akin to an action for breach of contract. Pet. App. 16a-17a. Finally, the court of appeals relied on this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), for the proposition that the THCLA claims did not overlap with ERISA § 502(a)(2), which permits actions for breach of fiduciary duty. Although the Fifth Circuit conceded that "*Pegram* did not decide the precise question before us," the court concluded that "its holding is broad enough to apply here," because evaluating Davila's assertion that he should have received coverage for Vioxx involves "the type of 'when and how' medical necessity questions . . . that fall within" what the court took to be "*Pegram*'s rule." Pet. App. 12a, 14a. The court accordingly held that Davila's claims were not completely preempted and

thus did not confer removal jurisdiction. *See* Pet. App. 20a, 29a.[8]

SUMMARY OF ARGUMENT

I. Under *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny, both Davila's state-law claims challenging Aetna's administrative determination that Vioxx was not covered under the Monitronics Plan and the remedies he seeks are preempted by ERISA.

A. This Court has repeatedly, and unanimously, held that ERISA's remedial provisions are not subject to supplementation by state law, and that any state-law remedy that offers plan participants a form of relief not available under ERISA is completely preempted.

1. This Court has recognized on numerous occasions that the causes of action and forms of relief available under ERISA are carefully balanced to fit the circumstances that Congress intended to address. *E.g.*, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 252 (1993). Given the complexity of the subject matter and the compromises inherent in regulating pension and welfare benefit plans, the Court has held that remedies and rights of action not expressly set forth in ERISA § 502(a) are affirmatively foreclosed. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). Accordingly, federal courts in ERISA actions may not award remedies not specifically authorized by the statute, such as consequential or punitive damages.

2. In *Pilot Life*, this Court made clear that the States likewise may not disturb the careful balance struck by Con-

[8] The case was subsequently remanded to Texas state court, where it has remained in abeyance pending this Court's ruling on the petition for a writ of certiorari and now on the merits.

gress by authorizing additional remedies for conduct actionable under ERISA (or by providing a right of action for conduct not actionable under ERISA). The Court held that a common-law claim for "bad faith" denial of benefits under a disability plan sought "remedies for the improper processing of a claim for benefits under an ERISA-regulated plan"—remedies "that Congress rejected in ERISA." 481 U.S. at 57. That same day, the Court held in *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), that ERISA § 502(a)'s preemptive force is so strong that any claim within its scope must be recharacterized as a federal action under ERISA and can be removed to federal court.

ERISA's remedial provisions strike a balance between competing interests, facilitating the swift and inexpensive recovery of benefits while affording plan administrators a degree of certainty and predictability that allows them to hold down costs. As the Court recognized in *Pilot Life* and *Metropolitan Life*, that closely interwoven compromise would unravel if state law were permitted to impose varying standards of care on plan administrators or authorize damage awards in the context of benefits administration. Thus, any state-law cause of action or remedy that would supplement ERISA § 502(a) is preempted.

3. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court unanimously confirmed that the remedies available under ERISA § 502(a) are the exclusive means of redressing ERISA-protected rights. The Court held preempted a state-law action that sought to supplement the ERISA remedies. And in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), all nine Members of the Court agreed that ERISA preempts any state law that gives plan participants a "new cause of action" or a "new form of ultimate relief."

B. Davila's complaint is that Aetna failed to approve coverage for Vioxx. Any contention that Vioxx was a cov-

ered medication under the terms of the Monitronics Plan, such that Aetna's failure to approve coverage was a violation of the plan, could be brought under ERISA § 502(a)(1)(B), which authorizes participants to sue to enforce the terms of the plan. Accordingly, Davila's state-law action would necessarily supplement the ERISA remedy, and is preempted under *Pilot Life*. Conversely, if Davila means to contend that Aetna had a duty to approve coverage for Vioxx notwithstanding the terms of the Monitronics Plan, any such contention would conflict with the plan itself. *Pilot Life* likewise preempts such a state-law action, which would impose duties on Aetna that are inconsistent with Aetna's obligations under ERISA.

II. The Fifth Circuit conceded that *Pilot Life* "arguably supports" Aetna's construction of ERISA § 502(a), but nevertheless held that Davila's state-law claims are not preempted by ERISA. Pet. App. 19a. In so doing, the court misread this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), and erroneously looked to a series of cases involving ERISA § 514.

A. The court of appeals concluded that because Aetna declined to cover Vioxx under the Monitronics Plan's "medical necessity" limitation, Aetna's decision was a so-called "mixed question of treatment and eligibility" that could be challenged under state law. This was a clear misreading of *Pegram*.

1. *Pegram* involved an action under ERISA for breach of fiduciary duty. Unlike the HMO in this case, the HMO in *Pegram* was owned and operated by the treating physicians. The Court held that when such physicians—the co-owners of the HMO—make "mixed eligibility and treatment decisions," they cannot be sued for breach of fiduciary duty under ERISA.

2. Unlike the physician co-owners of the group-model HMO at issue in *Pegram*, administrators of network-model

HMOs (such as Aetna's) do not make treatment decisions. The "mixed questions" referred to in *Pegram* simply do not exist outside the context of group- or staff-model HMOs, because network-model HMOs do not "act[] through their physicians." *Pegram*, 530 U.S. at 231. As the Solicitor General has explained, "[t]he better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians." Brief for the United States as *Amicus Curiae* at 8, *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (Nov. 7, 2001). Where, as here, the insurer provides no treatment, there is nothing "mixed" about its decision; the decision is a benefits determination that can be challenged only under ERISA.

3. This understanding is confirmed by *Metropolitan Life*, in which the Court recognized that the plaintiff's claims involved benefits administration even though the administrator's decision had a medical component. Similarly, in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), this Court recognized that coverage decisions are administrative even where the insurer takes into account medical evidence.

B. The complete preemption doctrine under ERISA § 502(a) is distinct from the preemption inquiry under ERISA § 514, which preempts state laws that "relate to" ERISA plans. Conflating the two inquiries, as the court of appeals apparently did, is a structural misapplication of ERISA.

This Court has consistently separated the complete preemption and defensive preemption inquiries. *E.g.*, *Ingersoll-Rand*, 498 U.S. at 142. In *Boggs v. Boggs*, 520 U.S. 833 (1997), for example, the Court held preempted state statutes that conflicted with individual provisions of ERISA, and expressly discounted the need to analyze the preemption claim under Section 514.

For this reason, recent cases tracing the outer boundaries of Section 514 are not instructive in applying Section 502.

Section 514 is so broad and potentially indeterminate that Congress may have intended the courts to define the outer limits of defensive preemption. Section 502, by contrast, is written with sufficient specificity to overcome the presumptions that have motivated this Court's Section 514 cases. *See Metropolitan Life*, 481 U.S. at 64, 66.

III. *Pilot Life* has been the law for nearly two decades, and there is no basis in law or policy for this Court to overrule it.

A. The *Pilot Life* line of cases further ERISA's goal of ensuring a flexible, uniform, and predictable system of benefit-plan regulation. The Nation's system of employer-provided health insurance has grown up in reliance on that framework, and this Court should not disrupt those settled expectations by now suddenly reversing course.

1. *Stare decisis* is strongest when, as here, Congress has left this Court's decisions undisturbed despite repeated reexamination of the subject area. Indeed, in enacting ERISA, Congress echoed and approved an earlier line of decisions by this Court that took a similarly robust approach to preemption under the Labor-Management Relations Act. This case in no way presents the sort of special justification needed to justify departing from a statutory-interpretation decision that has been clearly and consistently applied.

2. Virtually the entire system of employer-provided health benefits coverage has taken shape in reliance on *Pilot Life* and its progeny. Employers have embraced managed care, and the network-model HMO in particular, precisely because by confining the managed care entity's duties to claims administration, they subject it to ERISA's "uniform standards of primary conduct" and "uniform regime of ultimate remedial orders." *Rush Prudential*, 536 U.S. at 379. Managed care entities have set the prices they charge for their services accordingly. Subjecting those companies (and potentially others) to state-law standards that would override

the custom-designed terms of an employer's benefit plan would completely upset those pricing decisions, effectively requiring those companies (and employers) to offer a full-indemnity plan to participants who never had to shoulder the considerable costs associated with that form of coverage.

B. This Court's decision in *Pilot Life* leaves ample room for patient-protection regulation on both the federal and state levels. Congress, the States, and individual customers have already brought about pro-patient changes in employee health benefits—without disrupting the exclusivity of the judicial remedies that ERISA makes available.

1. Employers can use bargaining power with HMOs to dictate more generous medical-necessity criteria in ERISA plans. Likewise, both Congress and the States can and do mandate the inclusion of certain coverage terms in health benefit plans—terms that are judicially enforceable under the current ERISA framework. And, in limited circumstances, States may make available *nonjudicial* safeguards, such as the independent review that this Court approved in *Rush Prudential*, without opening the door to new and severe damages awards like the one Davila seeks.

2. Affirming the decision below and allowing plaintiffs like Davila to obtain such supplemental remedies would utterly undo the uniformity, predictability, and certainty that the *Pilot Life* line of decisions secures. Any such decision by this Court would swiftly and surely lead to further increases in the already high costs that employers and employees pay for health care. Such a decision, which would directly affect millions of workers and an entire sector of the American economy, is indubitably a legislative one. Davila and his supporters should address their challenge to *Pilot Life*—and to the system of employee benefits that relies on it—to Congress, not to this Court.

ARGUMENT

I. Davila's State-Law Tort Claims Would Frustrate ERISA's Remedial Exclusivity And Therefore Are Completely Preempted Under *Pilot Life*

The only dispute in this case is whether an action against Aetna based on its role in approving or disapproving the payment of benefits under the Monitronics Plan is a supplemental form of recovery that conflicts with, and thus is completely preempted by, ERISA's exclusive remedial provision. Under any reading of this Court's decisions construing Section 502(a), Davila's claims are completely preempted. Section 502(a) provides the sole means of relief for plaintiffs challenging benefits-administration decisions, and may not be supplemented by state-law remedies. The conduct that Davila challenges was plainly benefits administration: Aetna's sole interaction with Davila was in determining eligibility for benefits under the Monitronics Plan, and Davila's dispute with Aetna turns on whether Aetna, in performing claims-administration functions for the plan, should have approved his request for immediate coverage of Vioxx. The remedies that Davila seeks—compensatory and punitive damages—are not available in an ERISA action challenging the conduct in question. Davila's attempt to circumvent Section 502(a)'s careful limitation on permissible remedies is precisely what *Pilot Life* and its progeny foreclose.

A. Section 502(a) Provides A Comprehensive And Exclusive Means Of Enforcing Beneficiaries' Rights Under ERISA Plans

In an unbroken string of decisions, this Court has consistently concluded from ERISA's text, structure, and legislative history that ERISA's comprehensive remedial scheme forecloses additional state-law remedies. In the last seventeen years, the Justices of this Court have *unanimously* agreed on *four* separate occasions that ERISA's remedial

provisions are not subject to supplementation by state law, and that *any* alternative state-law remedy that offers plan beneficiaries a form of judicial relief not permitted by ERISA is completely preempted. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 54 (1987); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 62-63 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144-45 (1990); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002); *id.* at 388 (Thomas, J., dissenting) (agreeing with the Court majority on this point). Davila's action for damages under the THCLA is precisely the sort of impermissible state-law alternative that, under those cases, is preempted by ERISA, and the Fifth Circuit therefore erred in ordering Davila's state-law claims revived and remanded.

1. The Fifth Circuit's analysis was flawed chiefly because it neglected to analyze ERISA's *exclusive* remedial scheme as a whole, and instead focused only on whether Davila's THCLA claims precisely "duplicate[d]" individual rights of action or remedies expressly available under ERISA.[9] This Court's complete-preemption cases, however, turn on an understanding of the *overall* structure of ERISA's remedial scheme, including the remedies it forecloses as well as those it authorizes. The teaching of those cases is that preemption turns not on whether a state law duplicates an ERISA cause of action, but on whether the state law gives ERISA-plan participants a right of action or a remedy that Congress omitted from ERISA.

As this Court has recognized on numerous occasions, both the causes of action and the forms of relief available under Section 502(a) are carefully balanced and meticulously circumscribed to fit the circumstances that Congress intended to address. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 252

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[9] As CIGNA notes, the Fifth Circuit's "duplication" analysis was based on a misreading of *Ingersoll-Rand*. CIGNA Br. 18.

(1993) (ERISA is "an enormously comprehensive and detailed statute that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs"). For example, a beneficiary aggrieved by the incorrect denial of benefits due under the plan may recover the benefits denied him. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). The other actions are likewise limited. Even the most flexible remedial provision in Section 502(a)—subdivision (3)(B), which permits an action for "appropriate equitable relief"—contains limiting language that permits a federal court to award only certain core forms of relief that were "'*typically* available in equity.'" *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (quoting *Mertens*, 508 U.S. at 256).

Most significantly, Section 502(a)(1)(B) does not permit the award of legal relief—such as consequential and punitive damages other than withheld benefits. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) (Section 502(a)(1)(B) "says nothing about the recovery of extracontractual damages"). Consequential relief and punitive damages are not listed among the few forms of monetary relief that ERISA specifically makes available (such as benefits or statutory penalties).[10] Nor does Section 502(a)(3)(B) authorize awards of compensatory or punitive damages; that provision allows only "appropriate *equitable* relief," whereas "[m]oney damages are, of course, the classic form of legal relief" and are therefore precluded. *Mertens*, 508 U.S. at

[10] Section 502 permits a beneficiary to recover a monetary award in his own right—not the plan's—only in limited forms: a civil penalty against an administrator who does not comply with disclosure requirements, or benefits due under the plan. *See* ERISA § 502(a)(1)(A), (a)(1)(B), (c), 29 U.S.C. § 1132(a)(1)(A), (a)(1)(B), (c); *see also Russell*, 473 U.S. at 144 (only the plan may recover "appropriate relief" under Section 502(a)(2) for a fiduciary's breach of duty).

255; *accord, e.g.*, *Great-West*, 534 U.S. at 234 (Ginsburg, J., dissenting) (agreeing that Section 502(a)(3)(B) should be construed to retain the "large limitation" that "exclude[s] compensatory and punitive damages").

Given the complexity of the subject matter and the extensive study to which Congress devoted its comprehensive regulation of that area in ERISA, this Court has appropriately determined that remedies and rights of action not specifically enumerated in Section 502(a) were affirmatively foreclosed, not merely forgotten, by Congress. Section 502(a)'s "carefully integrated civil enforcement provisions" are "strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly." *Russell*, 473 U.S. at 146. Likewise, Congress's expansion of the class of potential fiduciary defendants from what the common law would have allowed counterbalances its limitation of the remedies available against those defendants. *Mertens*, 508 U.S. at 262. For this reason, this Court has been "especially 'reluctant to tamper with [the] enforcement scheme' embodied in the statute by extending remedies not specifically authorized by its text." *Great-West*, 534 U.S. at 209 (quoting *Russell*, 473 U.S. at 147) (alteration in original).

The general exclusion of monetary awards from ERISA's remedial scheme fits with the statute's overall emphasis on prospective remediation—to be accomplished where possible through internal review rather than through litigation. Indeed, a plan participant who is denied benefits by his ERISA plan is guaranteed a "full and fair review" by an "appropriate named fiduciary" without the need to pursue judicial remedies. ERISA § 503(2), 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(1). Because of the careful integration of Section 503, which provides for internal review, and Section 502, which provides for judicial review, the courts of appeals are in agreement that a plan participant *must* exhaust his remedies under the plan's procedures before bringing a

civil action for benefits under Section 502. *E.g.*, *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 & n.4 (6th Cir. 1998) (citing cases); *see also* 29 C.F.R. § 2560.503-1(*l*) (implicitly recognizing the existence of an exhaustion requirement). And although ERISA provides a disincentive to litigate by favoring nonjudicial remedies and limiting the availability of court-imposed relief, the statute also furnishes an appropriate counterbalance to the risk of "underenforcement of beneficiaries' statutory rights" by permitting courts to award successful ERISA plaintiffs their attorney's fees. ERISA § 502(g), 29 U.S.C. § 1132(g); *Russell*, 473 U.S. at 147.

Thus, "upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a comprehensive and reticulated statute," this Court has concluded that federal courts in ERISA actions may not award remedies not specifically authorized in the statute, such as consequential and exemplary damages. *Russell*, 473 U.S. at 146 (internal quotation marks omitted).

2. In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), a unanimous decision authored by Justice O'Connor, this Court announced the corollary to *Russell*'s limitation of federal expansion of ERISA remedies: States likewise may not disturb the careful balance struck by Congress by authorizing additional remedies for conduct actionable under ERISA. Such efforts to expand ERISA's remedial scope under state law are preempted by ERISA. *Pilot Life* controls this case and compels reversal of the Fifth Circuit's decision.

Pilot Life held preempted a state common law claim for "bad faith" denial of plan benefits. As in this case, plaintiff Dedeaux sought to import a state standard of reasonableness into the context of ERISA-governed benefits administration. When Pilot Life terminated his disability benefits under the terms of his ERISA plan, Dedeaux alleged that the termination was in "bad faith." *Id.* at 43. Rather than sue for the denied benefits under ERISA § 502(a), Dedeaux brought a tort

action under Mississippi law, seeking to recover compensatory and punitive damages. *Id.* at 43, 50.

This Court unanimously held that Dedeaux's claim was preempted by ERISA. Adopting the Solicitor General's suggestion, the Court held that the finely balanced nature of ERISA's civil enforcement scheme, which the Court had recognized in *Russell*, required that its status as the exclusive remedy for a benefits-administration decision be protected, by preemption if necessary. 481 U.S. at 53. In addition, in enacting ERISA, Congress had deliberately echoed the expansive preemption effected by Section 301 of the Labor-Management Relations Act, 29 U.S.C. § 185. That provision displaces all state-law claims predicated on contracts between unions and management, "even when the state action purport[s] to authorize a remedy unavailable under the federal provision." *Pilot Life*, 481 U.S. at 55. The Court in *Pilot Life* concluded that Congress had "modeled" Section 502(a)'s "pre-emptive force" on Section 301, and that Section 502(a) likewise preempts state-law claims that would supplement the remedies it provides. *Id.* at 54-55.

The Court noted in *Pilot Life* that Dedeaux's bad-faith claim for punitive damages amounted to an attempt to obtain state-law "remedies for the improper processing of a claim for benefits under an ERISA-regulated plan"—remedies "that Congress rejected in ERISA." Mindful of the potential disruption to Section 502(a)'s uniform enforcement scheme that a contrary holding would cause, this Court held his state-law claim preempted. 481 U.S. at 57.

That same day, this Court decided *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987)—also unanimous, also authored by Justice O'Connor. *Metropolitan Life* built upon *Pilot Life*'s holding by concluding that Section 502(a)'s preemptive force is so strong that any claim within its scope must be recharacterized as a federal claim—*i.e.*, one that can support removal jurisdiction. *Id.* at 65-66; *compare Fran-*

chise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 25-26 (1983) (defensive preemption under Section 514 does *not* confer removal jurisdiction). Thus, when plaintiff Taylor sued his employer and plan administrator in state court, alleging that they had wrongfully terminated his disability benefits, the tort and contract claims he alleged were "within the scope" of Section 502(a), and could be removed on that basis. *Metropolitan Life*, 481 U.S. at 62-63, 66.

The holdings in *Metropolitan Life* and in *Pilot Life* that the state-law claims could not proceed represented a straightforward application of well-settled preemption principles. ERISA's remedial provisions strike a balance between competing interests, facilitating the swift and inexpensive recovery of benefits while affording plan administrators a degree of certainty and predictability that allows them to hold down costs. *E.g.*, *Mertens*, 508 U.S. at 262-63; *Russell*, 473 U.S. at 146-47. That closely interwoven compromise would rapidly unravel if state law were permitted to undermine that certainty by imposing varying standards of care on insurers and authorizing large damage awards for any missteps. Thus, any state-law remedy that supplements or expands those that Congress included in Section 502(a) "pose[s] an obstacle to the purposes and objectives of Congress," even when—*especially* when—the state-law claim does not precisely overlap with the ERISA cause of action. *Pilot Life*, 481 U.S. at 52; *see Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). Under ordinary conflict preemption principles, such a supplemental remedy is barred.

3. Because the application of these preemption principles follows naturally from this Court's conclusion that ERISA's remedial provision is exclusive and does not authorize the award of non-enumerated forms of relief, this Court has remained consistent in its exposition of the preemption framework under Section 502(a). The core holding of *Pilot Life* remains unchallenged by even a single dissenting vote to

date: the exclusivity of Section 502(a) prevents States from creating alternative rights of recovery based on conduct that could be challenged under ERISA.

This Court unanimously confirmed in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), that the remedies available under ERISA § 502(a) are the exclusive means of redressing ERISA-protected rights, and that plaintiffs cannot circumvent Section 502(a)'s exclusivity simply by demanding different remedies. There, as here, a plaintiff sued in state court under Texas law, seeking compensatory and punitive damages; he had been fired by his employer and alleged that the termination was calculated to prevent his pension rights from vesting. *Id.* at 135-36. The Texas Supreme Court thought that because the plaintiff was not seeking the recovery of benefits that Section 502(a)(1)(B) guarantees, his action could proceed under state law despite the preemptive force of Section 502(a). *Id.* at 136 (citing *McClendon v. Ingersoll-Rand Co.*, 779 S.W.2d 69, 71 n.3 (Tex. 1989)). This Court reversed, holding that because ERISA protects employees from such terminations—just as it protects plan beneficiaries' right to receive benefits according to the terms of the plan—any relief for a violation of an ERISA-protected right must come under Section 502(a). *Id.* at 144-45.

The cases holding that Section 502(a) preempts state-law causes of action seeking forms of relief unauthorized by ERISA are summed up in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). There, this Court considered an Illinois statute that gave participants in an employee benefit plan the right to submit precertification decisions to an independent review organization (IRO). All Members of the Court agreed that had the Illinois statute authorized a "new cause of action" or a "new form of ultimate relief," it would plainly have been controlled by *Pilot Life* and its progeny. *Id.* at 379; *see id.* at 394 (Thomas, J., dissenting). A majority of the Court held that the claim seeking the IRO appeal was not com-

pletely preempted, because the statute allowed no new form of judicial review or relief—the IRO's decisions would be enforced pursuant to Section 502(a), and "the relief ultimately available would still be what ERISA authorizes in a suit for benefits under [Section 502(a)(1)(B)]." *Rush Prudential*, 536 U.S. at 379-80. Four Members of the Court contended that even though the statute did not create an unauthorized form of judicially awarded relief, *Pilot Life*'s rule was nonetheless applicable because arbitration, which the dissenting Justices viewed as analogous to the IRO's binding determination, "constitutes an alternative remedy to litigation." *Id.* at 395 (Thomas, J., dissenting). The Court was thus unanimous in considering damages claims like Davila's preempted.

Pilot Life and *Metropolitan Life* expressly held, and *Ingersoll-Rand* and *Rush Prudential* confirm, that an action is within the scope of ERISA's remedial provision—and is therefore completely preempted—if it challenges conduct that could have been challenged in an ERISA action, but takes a form not authorized by ERISA, *i.e.*, it purports to authorize actions for relief not permitted by ERISA or based on conduct not actionable under ERISA. A state law "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities" if, as the THCLA seeks to do in this case, the law "provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA." *Rush Prudential*, 536 U.S. at 379.

B. Davila's Challenge To Aetna's Interpretation Of The Monitronics Plan Is Preempted

Davila's claim, at bottom, is that Aetna failed to approve coverage for Vioxx. The complaint is somewhat ambiguous as to whether Davila contends that Aetna was required under the plan to pay for Vioxx or, alternatively, that Aetna was

required to pay for Vioxx regardless of the plan terms. Either way, however, his state-law claims are preempted by ERISA.

At times, Davila appears to assert that Vioxx was a covered medication. *See, e.g.*, Pet. App. 65a ("AEtna refused to provide Vioxx for relief of the pain caused by Juan Davila's arthritis his treating physician prescribed, *despite Vioxx being on the AEtna formulary*" (emphasis in original)). But if this is the basis of Davila's claims, his remedy lies under ERISA § 502(a)(1)(B), which authorizes a participant to sue in federal court "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). To be sure, it might be difficult to prevail on such a claim: Not only does the formulary make coverage for Vioxx conditional, but the Monitronics Plan expressly vests Aetna with discretion in the determination of coverage (J.A. 34-35) and, thus, Aetna's coverage determination would be reviewed with substantial deference. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). But as *Pilot Life* makes clear, the mere fact that state law may provide for more lenient standards, or additional remedies, does not authorize courts to ignore the comprehensive remedial scheme established under ERISA. 481 U.S. at 54 (cautioning that additional remedies would "completely undermine[]" ERISA).

At other times, Davila appears to assert that Aetna was obliged to cover Vioxx notwithstanding the terms of the Monitronics Plan. *See, e.g.*, Pet. App. 68a-69a ("AEtna failed to use ordinary care in . . . making health-care decisions regarding Juan Davila through its *adherence* to its prescription drug formulary policies" (emphasis added)). But if this is Davila's claim, it directly conflicts with ERISA § 502(a)(1)(B), which authorizes a participant to sue to "*enforce* his rights *under the terms of the plan*." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). The express right to enforce the terms of the plan necessarily precludes any putative state right to alter, amend, or modify the terms of the plan, let

alone one to hold the plan's insurer liable for punitive damages merely for adhering faithfully to those terms. Davila's claims, which would require ignoring the plain language of the plan, are clearly precluded by *Pilot Life* and its progeny. *See, e.g.*, *Rush Prudential*, 536 U.S. at 379-80, 386 (confirming that challenges to plan design are completely preempted if they authorize a "form of ultimate relief" not allowed under ERISA).[11]

Accordingly, however characterized, Davila's THCLA claims fall within the scope of ERISA's remedial provision. Davila could have sought redress through the internal review procedures spelled out in the Secretary of Labor's regulations, or filed an action in federal court. Yet Davila opted instead to proceed with state-law claims seeking relief that is unavailable under ERISA for a supposed violation of an ERISA-protected right, just as the plaintiff in *Ingersoll-Rand* sought damages—rather than the available injunctive or "other appropriate equitable relief" available under Section 502(a)(3)—for an alleged termination motivated by a desire to avoid paying pension benefits. *See* 498 U.S. at 142-43; *see also Pilot Life*, 481 U.S. at 43-44, 52 (Dedeaux's damages claim was based on the "improper processing of a claim for benefits" and was therefore preempted, even though Dedeaux had styled it as a suit for tortious breach of contract). Therefore, under *Pilot Life* and its progeny, Davila's claims are completely preempted.

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[11] Indeed, had Aetna departed from the terms of coverage as Davila claims state law demands, it and Monitronics would have been subject to suit for a "violat[ion of] the terms of the plan." ERISA § 502(a)(3)(A); *see also id.* § 502(a)(3)(B)(ii). Plainly, "when compliance with both state and federal law is impossible," conflict preemption principles require that the state law yield under the Supremacy Clause. *E.g.*, *United States v. Locke*, 529 U.S. 89, 109 (2000) (citations and internal quotation marks omitted).

II. The Fifth Circuit Erred In Failing To Apply The Settled Rule Of *Pilot Life* And Its Progeny

Because *Pilot Life* and its progeny are directly on point, the question of preemption presented to the court of appeals was a straightforward one. Indeed, the court of appeals conceded that "*Pilot Life* . . . arguably supports CIGNA and Aetna's reading" of Section 502, although it characterized the basic principles of remedial exclusivity and conflict preemption discussed above as merely "expansive language." Pet. App. 19a. The Fifth Circuit justified disregarding this Court's holding in *Pilot Life* based on impressions it derived, incorrectly, from other ERISA cases.

Even were the Fifth Circuit not squarely precluded from reexamining this Court's precedents of its own volition,[12] the cases on which it premised its bobtailed reading of *Pilot Life*—*Pegram v. Herdrich*, 520 U.S. 211 (2000), and a series of cases construing ERISA § 514—do not justify its departure from precedent.[13] *Pegram* resolved a question of fiduciary liability—not preemption—applicable to treating physicians who are also HMO co-owners, and who consequently must engage in *both* medical treatment and coverage interpretation. An HMO that provides no medical services does

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[12] *See, e.g.*, *State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997); *Agostini v. Felton*, 521 U.S. 203 (1997); *Rodriguez de Quijas v. Shearson/Am. Express Inc.*, 490 U.S. 477, 484 (1989).

[13] The Fifth Circuit also invoked *Rush Prudential* as a basis for its assertion that "*Pilot Life* does not sweep so broadly" (Pet. App. 19a), but as discussed above, *Rush Prudential* in fact *reaffirms* that States may not create a "new cause of action under state law and authorize[] a new form of ultimate relief," particularly one that, like the punitive and consequential damages Davila seeks, "'Congress rejected in ERISA.'" *Rush Prudential*, 536 U.S. at 378, 379 (quoting *Pilot Life*, 481 U.S. at 54); *see supra* pp. 25-26; *see also* CIGNA Br. 10, 18-21.

not make "treatment decisions" that can be challenged under state law standards without regard to ERISA; it makes only coverage determinations, for which Section 502(a) provides the exclusive vehicle of judicial review. And because the THCLA claims conflict directly with the exclusivity of Section 502(a), there is no need to engage in the wholly distinct preemption analysis prescribed by Section 514.

A. State-Law Challenges To "Medical Necessity" Coverage Determinations Are Preempted By ERISA

The preemption doctrine developed in *Pilot Life* and its progeny is fully applicable to *any* state-law challenge to a coverage decision. It makes no difference whether that decision is based on an interpretation of a specific exclusion, a copayment requirement, or (as here) a "medical necessity" requirement that incorporates both financial and medical criteria. The court of appeals, however, concluded that a medical necessity determination is a so-called "mixed eligibility and treatment decision" that is not subject to ERISA's exclusive remedial scheme. Pet. App. 13a. This was a clear misreading of this Court's decision in *Pegram*.

1. *Pegram* involved an action under ERISA for breach of fiduciary duty. The plaintiff, Herdrich, was a participant in a group-model HMO, in which the physicians owned the HMO *and* provided medical services to HMO participants.[14] Unlike a network-model HMO (such as the one at issue in this case), the HMO in *Pegram* did not reimburse doctors for providing covered services; rather, the HMO compensated its physician co-owners according to the quantity of services they provided through the HMO each year. *See* 530 U.S. at 216 n.3; Ann Barry Flood et al., *The Promise and Pitfalls of Explicitly Rewarding Physicians Based on Patient Insurance*,

[14] *See supra* note 1 (discussing different HMO models).

23 J. AMBULATORY CARE MGMT. 55, 58, 62 (2000) (detailed study of the HMO that was the petitioner in *Pegram*).

Herdrich alleged that the physician (and HMO co-owner) who examined her discovered an inflamed mass in her abdomen, but did not order an immediate ultrasound. Instead, Herdrich's doctor directed her to wait the eight days necessary for the ultrasound to be provided by a facility owned by the HMO. During that time, Herdrich's appendix ruptured. She sued, asserting that the HMO had a fiduciary duty to make determinations in the best interests of the patient, and that this duty was automatically breached by the HMO's organization along lines that rationed care on the basis of cost-saving principles. 530 U.S. at 216. This Court rejected that claim.

The *Pegram* Court articulated a tripartite framework for evaluating ERISA claims alleging breach of fiduciary duties by HMOs that act through their physician owners. "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment"; "'[t]reatment decisions' . . . are choices about how to go about diagnosing and treating a patient's condition"; and "mixed eligibility and treatment decisions," including "medical necessity determinations," have aspects of both. 530 U.S. at 228-29. The holding of *Pegram* is that "Congress did not intend [the HMO at issue] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." *Id.* at 231.

2. The court of appeals recognized, but failed to appreciate the significance of, the crucial distinction between this case and *Pegram*. The court acknowledged that "Herdrich claimed that her doctor made the erroneous medical decision," whereas Davila claimed that the HMO (Aetna) did. Pet. App. 14a. The court said, however, that "*Pegram*'s reasoning indicates that this distinction is immaterial to the § 502(a)(2) analysis." *Id.* Aside from the fact that this is not

a Section 502(a)(2) case alleging breach of fiduciary duty (since Davila has refused even to attempt to plead a claim under ERISA),[15] Aetna *does not make* medical decisions under the Monitronics Plan. *See* J.A. 106 ("Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all Medical Services which are rendered by Participating Physicians" (boldface omitted)).

Unlike physician owners of a group-model HMO, administrators of network-model HMOs do not make treatment decisions. This Court recognized as much in *Pegram*: "Traditional trustees administer a medical trust by paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well. *Private trustees do not make treatment judgments*, whereas treatment judgments are what physicians reaching mixed decisions do make, by definition." 530 U.S. at 231-32 (emphasis added). The "mixed questions" referred to in *Pegram* simply do not exist outside the context of the physician-

[15] The court below said that Aetna was "not acting as [a] plan fiduciar[y] when denying [Davila] medical treatment." Pet. App. 12a. There are two problems with this statement. First, Aetna did not deny Davila any medical treatment; it simply determined that Vioxx was not a covered benefit that it could pay for under the plan. Davila remained free to have his Vioxx prescription filled or to challenge Aetna's coverage decision. Second, it makes no difference for purposes of complete preemption whether or not Aetna was acting in a fiduciary capacity. Section 502(a) provides the exclusive remedies available for subscriber grievances arising out of plan administration, against both plan fiduciaries *and* non-fiduciaries. Indeed, one provision (Section 502(a)(2)) applies only to breaches of fiduciary duty (*see* ERISA § 409, 29 U.S.C. § 1109), indicating that the remainder are available to the identified plaintiffs regardless of the fiduciary status of the defendant. *E.g.*, SACHER, *supra*, at 901.

owned HMO at issue in that case, or a staff-model HMO, because network-model HMOs do not "act[] through their physicians." *Id.* at 231; *see id.* at 237 ("We hold that mixed eligibility decisions *by HMO physicians* are not fiduciary decisions under ERISA"); *accord* CIGNA Br. at 31-32. *Compare* J.A. 106 ("No Participating Provider . . . is an agent or employee of [Aetna]" (boldface omitted)). As a result, *Pegram* has nothing to do with this case.[16]

Although standards of care or treatment may enter into the "medical necessity" determination, they do so in aid of a pure coverage judgment—*i.e.*, must the plan pay for this proposed treatment?—and the ultimate decision to approve or deny coverage based on that plan term thus remains one of plan administration. In this case, it cannot be disputed that Vioxx can be approved only conditionally under the Monitronics Plan formulary, and it is likewise plain that no precondition to approval was met. Aetna's decision that Vioxx was not "medically necessary" thus was not a treatment decision, but rather reflected the terms of the plan itself. And the only person who *treated* Davila's condition by recommending that Davila try Naprosyn was his attending physician.

Because the structure of a physician-owned HMO requires "the physicians through whom [such] HMOs act" to make mixed eligibility and treatment decisions, patients can—as Herdrich in fact did (*see* 530 U.S. at 217)—obtain

[16] The Court stated in *Pegram* that it was "not in a position to derive a sound legal principle to differentiate [the group model HMO at issue] from other HMOs." 530 U.S. at 222. This statement was made in the context of fiduciary "decisions made by all HMOs *acting through their owner or employee physicians*." *Id.* (emphasis added). Aetna's HMO products, including the services it provides the Monitronics Plan, are not owned by and do not employ treating physicians, and thus there is a sound—indeed, dispositive—basis of distinction.

adequate relief for deficient care through traditional medical malpractice actions against the *physicians*. Of course, medical malpractice actions logically cannot be available against HMOs that do not provide medical services, or against physician-owned HMOs in States that do not subject managed care entities to the same level of state-law regulation as the individual physician owners. But, the Court noted, "we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize *malpractice* litigation . . . for any other reason." *Id.* at 236 (emphasis added). ERISA federalizes only *benefits* litigation, and federalizes it completely, as *Pilot Life* established.

3. *Metropolitan Life* confirms that ERISA provides the exclusive means of challenging a benefits decision by an insurer that provides no treatment, even if the benefits decision includes some medical criteria. In that case, the employee (Taylor) had been found medically able to work and his disability insurance had therefore been terminated. 481 U.S. at 60-61. Despite the medical component of the insurer's decision (*see Taylor v. Gen. Motors Corp.*, 763 F.2d 216, 217-18 (6th Cir. 1985)), this Court recognized that Taylor's claims challenged benefits administration and, therefore, were maintainable under ERISA § 502(a) or not at all. 481 U.S. at 62-63 (characterizing Taylor's action as "a suit by a beneficiary to recover benefits from a covered plan" that was preempted by the "exclusive federal cause of action for resolution of such disputes"). The court of appeals' decision in this case is flatly irreconcilable with the holding of *Metropolitan Life*.

Indeed, just last Term this Court recognized in an analogous ERISA-determination context that although plan documents may incorporate certain medical concepts as eligibility criteria, the award of benefits under those plan documents is nonetheless a question of benefits administration rather than medical judgment. The dispute in *Black & Decker Disability*

Plan v. Nord, 123 S. Ct. 1965 (2003), concerned the award of benefits under a disability-insurance plan, under which the key eligibility determination was whether, "based on suitable medical evidence" and the employee's job history, the employee was medically able to continue in his regular occupation. *Id.* at 1967. The unanimous *Nord* opinion aptly explains the importance of treating these quasi-medical determinations as only one element in an insurer's determination that benefits are or are not authorized. In deciding how challenges to such decisions should be reviewed, this Court noted that while the opinion of a physician is one element—not *per se* entitled to any "special weight"—in the decision, the judgment "'is likely to turn,' in large part, 'on the interpretation of terms in the plan at issue.'" *Id.* at 1971 (quoting *Firestone Tire*, 489 U.S. at 115). *Nord* conclusively establishes that medical necessity determinations under an ERISA plan concern benefits administration, not medical treatment.

Thus, outside the unique context presented in *Pegram*, in which HMO co-owners provided medical treatment, that case's discussion of mixed eligibility and treatment decisions has no relevance to ERISA preemption. Where the treating physician's role is kept *separate* from benefits administration, the complete preemption doctrine has *no* effect on a plan beneficiary's ability to pursue a state-law remedy against his physician based on treatment, and ERISA creates no risk that malpractice litigation will be unnecessarily "federalize[d]." As the Solicitor General has explained, "[t]he better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians." Brief for the United States as *Amicus Curiae* at 8, *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (Nov. 7, 2001). Indeed, any other reading of *Pegram* would contravene "the background . . . provisions of ERISA itself and longstanding Labor Department regulations." *Id.* at 9. Properly understood, *Pegram* does not disturb the core holding of *Pilot Life* and its progeny: ERISA continues to provide the exclusive means of challenging a

non-treating claims administrator's interpretation of the plan and completely preempts all alternative remedies, even if the plan incorporates a criterion such as "medical necessity."

Several courts of appeals have recognized that *Pegram* does not alter the preemption analysis of *Pilot Life*. The Third Circuit has stated its conclusion most plainly: "[T]he Court's holding that a 'mixed' determination made by a physician owner does not subject an HMO to liability for breach of fiduciary duty does not translate to, or govern in, the preemption context." *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 450 (3d Cir. 2003).[17] The Third Circuit went on to hold preempted a state-law medical-negligence claim challenging an insurer's decision that had "aspects of treatment and coverage." Applying a "medical necessity" requirement substantially identical to the Monitronics Plan's, Aetna had allegedly denied coverage for a specialized tracheostomy tube. Although in reaching that decision "Aetna necessarily had to exercise some medical judgment," the Third Circuit held that the determination nonetheless "could only have [been] an eligibility, not a treatment, decision," because Aetna did not itself provide the medical services. *Id.* at 448-49. Thus, applying both *Pegram* and its own, related precedent, the Third Circuit concluded that despite the aspects of diagnosis bound up with the plan determination, the decision was an eligibility determination and could be challenged under ERISA or not at all. *Accord, e.g.*, *Cicio v. Doe*, 321 F.3d 83, 109 (2d Cir. 2003) (Calabresi, J., dissenting in part) ("If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is"), *petition for cert. filed*, No. 03-69 (docketed July 14, 2003).[18] Expanding *Pegram*'s "mixed eligibility and treatment decision" formulation outside the context of physician-owned HMOs would completely undo *Pilot Life*, because virtually *any* determination by a health or disability plan insurer can be characterized as a mixed question.

[17] The Third Circuit spoke with particular authority in this regard, because *Pegram*'s tripartite framework consciously echoed the analysis in an earlier Third Circuit decision. *Pegram*, 530 U.S. at 228 (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995)). Although *Dukes* inaccurately blurred the distinction between HMOs' precertification of benefits and doctors' prescription of treatment, this Court recognized in *Pegram*, and the Third Circuit agreed in *DiFelice*, that that distinction blurs into a "mixed eligibility and treatment decision" *only* when the doctor works directly for or owns the HMO.

B. Recent Decisions Construing ERISA § 514 Do Not Alter The *Pilot Life* Analysis

The Fifth Circuit's determination to read *Pilot Life* narrowly may also have been influenced by its analysis, in the consolidated opinion, of the entirely distinct concept of defensive preemption under ERISA § 514, 29 U.S.C. § 1144, which under then-existing circuit precedent was deemed to be a component of the complete-preemption analysis under ERISA § 502(a). However, as the Fifth Circuit has since recognized in another case, the displacement of supplemental state-law remedies follows directly from principles of con-

[18] Several other circuits have likewise recognized that medical necessity determinations are benefits decisions, not treatment decisions, and that state-law tort challenges to those determinations are preempted under *Pilot Life*. *See, e.g.*, *Marks v. Watters*, 322 F.3d 316, 325-27 (4th Cir. 2003); *Hotz v. Blue Cross & Blue Shield of Mass.*, 292 F.3d 57, 60 (1st Cir. 2002) (reaffirming *Danca v. Private Health Care Sys.*, 185 F.3d 1, 5-6 (1st Cir. 1999)). A few other circuits have misread *Pegram* as the court below did. *See, e.g.*, *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1290-93 & n.5 (11th Cir. 2003), *petition for cert. filed*, No. 03-649 (docketed Oct. 30, 2003); *Cicio*, 321 F.3d at 102.

flict preemption.[19] Thus, the form of preemption for which *Pilot Life* and *Metropolitan Life* stand—"complete preemption"[20]—does not turn on interpretation of ERISA's broad defensive preemption clause, and *Pilot Life*'s core holding cannot be constricted based on augury of the signals allegedly sent by this Court's decisions interpreting Section 514.

ERISA § 514 preempts any aspect of state law that "relate[s] to" an ERISA plan. As this Court has noted, if that provision were applied literally, "then for all practical purposes pre-emption would never run its course." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* ("*Travelers*"), 514 U.S. 645, 655 (1995). Accordingly, a number of this Court's recent decisions—including the so-called "trilogy" of *Travelers*; *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997)—have sought to give some definition to the outer boundary of defensive preemption. However, as Davila himself notes, "section 502(a) complete preemption is very different from section 514's 'relates to' preemption." Br. in Opp. 1 n.1.

In cases following *Pilot Life* and *Metropolitan Life*, therefore, this Court has appropriately separated the com-

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[19] Fifth Circuit precedent formerly dictated that in order to support removal under *Metropolitan Life*, a claim must be both completely preempted by Section 502(a) *and* defensively preempted by Section 514. *See, e.g., Hartle v. Packard Elec.*, 877 F.2d 354, 355 (5th Cir. 1989). The Fifth Circuit has since overruled those precedents. *Arana v. Ochsner Health Plan*, 338 F.3d 433, 440 (5th Cir. 2003) (en banc), *petition for cert. filed*, No. 03-542 (docketed Oct. 10, 2003).

[20] "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life*, 481 U.S. 63.

plete-preemption and defensive-preemption inquiries. *See, e.g., Ingersoll-Rand*, 498 U.S. at 142 ("*Even if there were no express pre-emption in this case*, the Texas cause of action would be pre-empted because it conflicts directly with an ERISA cause of action" (emphasis added)); *accord Rush Prudential*, 536 U.S. at 377 (anticipating that a saved "state insurance regulation los[es] out if it allows plan participants 'to obtain remedies . . . that Congress rejected in ERISA'" (quoting *Pilot Life*, 481 U.S. at 54) (alteration in original)).[21]

This Court's cases construing other ERISA provisions have likewise concluded that a direct conflict with a specific provision of ERISA compels a finding of preemption and does not require resort to the defensive-preemption clause. Thus, for example, in *Boggs v. Boggs*, 520 U.S. 833 (1997), this Court held preempted state statutes that conflicted directly with individual provisions of ERISA, and expressly discounted the need to analyze the preemption claim under the more general rubric of Section 514. *Id.* at 841 (holding that because state community property law conflicts with ERISA's "anti-alienation" provision, application of conflict preemption principles "suffices to resolve the case," and the Court "need not inquire whether [Section 514] provides further and additional support for the pre-emption claim").

For this reason, cases construing ERISA's defensive-preemption provision relatively broadly or relatively nar-

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[21] The propriety of separate analysis of the two provisions is confirmed by cases construing other defensive-preemption provisions. *See Geier v. American Honda Motor Co.*, 529 U.S. 861, 869 (2000) ("[T]he saving clause (like the express pre-emption provision) does not bar the ordinary working of conflict pre-emption principles"); *Freightliner Corp. v. Myrick*, 514 U.S. 280, 287-89 (1995) (the inclusion of an express preemption clause does not foreclose the preemption of additional, directly conflicting state laws).

rowly are not instructive in applying the conflict-preemption principles that Section 502(a) invokes. Congress wrote Section 514 so broadly that it may plausibly have meant to delegate to this Court the authority to make relatively fine judgments based on the policy of ERISA and the competing state interests at stake. *Cf. Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 687-88 (1978) (noting that the Sherman Act has language so broad "that it cannot mean what it says," and explaining that Congress "expected the courts to give shape to the statute s broad mandate by drawing on common-law tradition"). In Section 502(a), by contrast, Congress spoke with sufficient clarity to overcome the presumptions that have motivated some of this Court's recent retrenchments in ERISA-preemption cases. *E.g.*, *Ingersoll-Rand*, 498 U.S. at 144 ("It is clear to us that the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrants pre-emption in this case" (internal quotation marks and alterations omitted)); *see also Metropolitan Life*, 481 U.S. at 64, 66 (referring to the "explicit direction from Congress" and observing that "[n]o more specific reference to the *Avco* rule [of exclusive remedies and complete pre-emption of alternatives] can be expected").[22]

III. This Court Should Not Overrule The *Pilot Life* Line Of Cases

As demonstrated above, Davila's claims are foreclosed by the core holdings of *Pilot Life* and its kin—that ERISA's remedial provision is exclusive; that that exclusivity gives rise to preemption of any state cause of action within its scope; and that preemption is so complete as to confer re-

[22] And even in its recent Section 514 cases, this Court "ha[s] not hesitated" to find an "area[] of traditional state regulation" to be "pre-empted when it conflicts with ERISA or relates to ERISA plans." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001).

moval jurisdiction. Having adhered consistently to those principles over the nearly two decades since *Russell* was decided, this Court should decline any request that it reexamine these settled precedents.

A. Overruling *Pilot Life* Would Undermine The Settled Expectations Of Insurers, Employers, And Participants

A retreat from *Pilot Life* would allow the plaintiffs' bar to mount a frontal assault on the concept of managed care, an assault that both Congress and this Court have declined to countenance. Using state laws such as the THCLA, plan participants would seek benefits that they neither contracted nor paid for, driving up costs for insurers and employers, and ultimately for employees. Such a liability regime is wholly inconsistent with ERISA as this Court has consistently construed it, and there is no basis in law or logic to depart from that longstanding construction.

1. The principle of *stare decisis* bears "special force in the area of statutory interpretation." *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989). Not only does the general value of certainty and predictability in application of the law counsel against overruling a statutory precedent; so too does a sound conception of the relationship between the judicial and the legislative power, because Congress retains the ability to overrule any construction that it deems incorrect as a matter of law or inadvisable as a matter of policy. *Id.* Therefore, in order even to ask this Court to part company with the *Pilot Life* line of cases, Davila and his *amici* must show, in addition to the "special justification" required of all who seek a departure from *stare decisis* (*Arizona v. Rumsey*, 467 U.S. 203, 212 (1984)), an additional basis for overcoming the "presumption of adherence" to statutory-interpretation precedents. *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 736 (1977). This is a showing they cannot make.

Moreover, the circumstances of this case fail to demonstrate the "necessity and propriety" (*Patterson*, 491 U.S. at 172) of overruling a statutory interpretation that has been consistently adhered to—and without dissent—for almost two decades. *Cf. Illinois Brick*, 431 U.S. at 737 (adhering to a construction "joined by eight Justices without dissent only a few years ago"). None of the indicia of legislative intent on which this Court relied in *Pilot Life* has been discredited or superseded. No significant change has been made in Section 502(a) that would justify a reexamination of the core holding of several past decisions consistently interpreting that statute. Indeed, Congress has enacted sundry amendments to Section 502(a) since *Pilot Life* and *Metropolitan Life* were decided, but has made no change that would suggest disapproval of the notion of exclusivity or of the doctrine of complete preemption.[23] And this Court's cases have consistently adhered to *Pilot Life* and its progeny; with the passage of time and the ratification of subsequent—unanimous—decisions, any assertion that the *Pilot Life* family of cases is aberrational becomes all the more implausible. Indeed, this Court generally reaffirmed and expanded upon the complete-preemption

[23] To the contrary: even "patients' rights" legislation that Congress has considered (but failed to pass) in recent years has adhered to the principle that any damages remedy for eligibility determinations under an ERISA plan should be exclusively *federal*. *See* H.R. 2563, § 402 (2001) (passed by the House). Although some Members of Congress have proposed legislation to undo the exclusivity recognized in *Pilot Life*, no such legislation has ever been enacted, and even those proposals have recognized that any overruling of *Pilot Life*'s preemption holding would have to be accompanied by limitations on state-law damages and continued adherence to ERISA's exhaustion requirements, to avoid a radical increase in health care costs. *See* S. 1052, § 402(b) (2001).

analysis in *Metropolitan Life* just last Term. *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062-63 (2003).[24]

2. This Court should be particularly hesitant to overrule wholesale a line of cases in which American employers, employees, and employee benefit plans have invested such considerable reliance. The complexity of the compromise that produced Section 502(a) bespeaks the considerable importance of maintaining that compromise. In selecting the available remedies and foreclosing others, Congress struck a balance between "the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing [benefit] costs." *Mertens*, 508 U.S. at 262-63 (internal quotation marks omitted). Indeed, employers (including the federal government) have embraced the HMO model precisely because that model confines the managed care entity's duties to plan administration, subjecting it to ERISA's "*predictable* set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential*, 536 U.S. at 379 (emphasis added); *see* AAHP-HIAA Amicus Br. 16-17. To undo the balance struck in 1974 and consistently adhered to by this Court would cause a significant shock to the Nation's system of employee benefits and would require employees to bear increased premiums, decreased coverage, or both. *See* U.S. Chamber Amicus Br. 24-26.

The predictability of the ERISA remedial framework has been relied upon to price tens of thousands of employee benefit contracts since *Pilot Life* was decided. Insurers and

[24] Even if one does not accept as an original matter that complete preemption is sufficient to confer removal jurisdiction, one may fairly agree that Congress expressly endorsed such a result in the ERISA context by adopting language strikingly parallel to the LMRA's. *Beneficial*, 123 S. Ct. at 2067 n.1 (2003) (Scalia, J., dissenting).

administrators of ERISA benefit plans have been cognizant of their responsibilities and their liabilities under the governing law, and have set their premiums and fees accordingly. For this Court now to allow the imposition of state-law standards that would override the plan terms would completely undo those actuarial pricing decisions. That course would simply confer a windfall on plaintiffs who never had to pay the higher costs associated with a fee-for-service plan (and would impose additional costs on future participants). At a time when medical costs are already high, affirmance of the decision below would deal a severe blow to the American economy.

The current system has not proved unworkable or judicially unmanageable. Indeed, the very prevalence of managed care strategies strongly suggests that the cost-containment strategies that this Court has identified as HMOs' *raison d'être* have succeeded in lowering premiums while maintaining an acceptable quality of benefits. This Court should not now decree an end to that widely adopted model of health coverage.

B. Overruling *Pilot Life* Is Not Necessary To Protect Participants Or Plan Benefits

That ERISA forecloses one crude means of regulating health plans—tort actions for money damages—certainly does not mean that health care consumers and state regulators enjoy no meaningful influence over the appropriate levels of medical care. To the contrary, plan members, employers, and state governments all retain substantive and valuable roles both in specifying the plan language that sets out these medical and non-medical criteria to be used in the HMO's coverage decision, and in regulating the application of that plan language.

1. Plan members and employers, for example, can use their bargaining or purchasing power to secure more gener-

ous coverage provisions, which increase the likelihood that care will be provided and, accordingly, increase premiums by a certain amount (depending on the size of the risk pool in which the ERISA plan participates). And medical professionals may refuse to participate in any particular HMO whose benefit plans depart too often from what treating physicians, exercising their Hippocratic obligations, see as appropriate medical treatment. Because HMOs' ability to offer cost savings turns in part on their relationship with in-network providers, the doctors have leverage as well.

In addition to encouraging market-based solutions, Congress has required health benefit plans to cover certain services that, in Congress's judgment, should not be subject to contractual exclusions. *See, e.g.*, Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 to -437 (codified at ERISA § 713, 29 U.S.C. § 1185b); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603, 110 Stat. 2874, 2935-28 (codified at ERISA § 711, 29 U.S.C. § 1185). In adding these mandated-benefits provisions to ERISA (while leaving employers otherwise free to design their own plan terms, *see Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)), Congress has recognized that the rights of action provided by Section 502(a) are adequate to enforce the required substantive elements of benefit plans.

Significantly, state regulation also may play a constructive role without tampering with ERISA's exclusive remedies: this Court has recognized that States may permissibly regulate the substantive terms of insurance plans by requiring, for example, that all health insurance coverage offered within a State include a certain minimum set of covered benefits. *E.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985) (upholding as not preempted a state statute requiring health plans to include coverage for mental health, and stating, "If a state law 'regulates insurance,' as

mandated-benefit laws do, it is not pre-empted"). So long as the regulation is "specifically directed toward" insurance companies and "substantially affect[s] the risk pooling arrangement between the insurer and the insured," it is saved from preemption under Section 514(b)(2)(A)'s insurance saving clause. *Kentucky Ass'n of Health Plans v. Miller*, 123 S. Ct. 1471, 1479 (2003).[25]

This Court has already given effect to one of the most significant forms of state regulation of insurers' eligibility determinations: the independent review organization. Recently in *Rush Prudential*, this Court held that Sections 502 and 514 do not preclude States from requiring HMOs to submit their benefit-eligibility determinations based on medical necessity to an independent review organization, at the claimant's election. The IRO procedure does not create any additional right to recovery of money damages; instead, it allows the independent reviewer rather than the HMO to have the final say as to "what is 'medically necessary' under [the plan] contract." *Rush Prudential*, 536 U.S. at 380. If necessary, a beneficiary can sue under ERISA to enforce

[25] Self-funded ERISA plans cannot be subjected to state mandated-benefits laws, because they are excluded from the set of saved state insurance regulations by Section 514's "deemer clause," 29 U.S.C. § 1144(b)(2)(B). *See, e.g.*, *Metropolitan Life v. Massachusetts*, 471 U.S. at 747 ("We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter"); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (explaining that self-funded plans are covered by the deemer clause exception). Of course, self-funded plans likewise cannot be subjected to alternative state-law remedies, because ERISA § 502(a)'s independent form of conflict preemption affects both self-funded and independently insured ERISA plans.

compliance with the IRO requirement or, once the IRO rules on the claim for coverage, to recover the benefits to which the IRO finds him entitled. *Id.* at 380 & n.10; *see also* U.S. Chamber Amicus Br. 20-21 (citing state IRO laws).

The Secretary of Labor, in regulations implementing Section 503's internal-appeal requirement, has expressly sanctioned these IRO procedures and deemed them consistent with ERISA, so long as they remain both independent and voluntary (*i.e.*, at the beneficiary's election). *See* 29 C.F.R. § 2560.503-1(k)(2). Texas was one of the first States to implement an IRO law, and the Monitronics Plan incorporates IRO review. J.A. 94-95. Consistently with the terms of the plan, Aetna advised Dr. Lopez that Davila could invoke his right to IRO review if he were dissatisfied with the denial of immediate coverage for Vioxx (Pet. App. 81a), but Davila states in his complaint that he did not do so. *Id.* at 69a-70a. And even had an IRO reversed Aetna's decision that Vioxx had not yet been shown to be covered in Davila's case, Davila would still have been unable to sue for the compensatory and punitive damages that he now demands: A permissible IRO provision "does not enlarge the claim beyond the benefits available in any action brought under [Section 502(a)]." *Rush Prudential*, 536 U.S. at 380. By contrast, Davila seeks to assert a "new cause of action under state law" and to recover "a new form of ultimate relief"—claims that are "patently" preempted. *Id.* at 379.

Where the States are foreclosed from regulating is in prescribing additional *remedies* for breach of these state-mandated obligations. *Rush Prudential*'s focus on the non-remedial nature of Illinois's IRO law makes plain this core area of *Pilot Life* preemption. Likewise, in *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), this Court distinguished between a permissible state law that provides the "relevant rule of decision" in a suit under ERISA § 502(a)(1)(B) to recover benefits due, and an impermissible

state cause of action that supplements the exclusive remedial scheme of ERISA § 502(a). *Id.* at 377. Thus, while this Court has upheld state laws imposing new standards on insurance policies offered through employee benefit plans—noting that the attendant "disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation," *id.* at 376; *Metropolitan Life v. Massachusetts*, 471 U.S. at 747—it has foreclosed state attempts to supplement their unique standards with new causes of action and forms of relief that diverge from those available nationwide under ERISA.

Saving substantive risk-related regulation, but foreclosing supplemental remedies, fosters predictability and reduces the cost of benefits administration—two important goals of ERISA. Allowing the mandatory addition of terms to insurance contracts leaves the insurer—or the ERISA plan—free to perform its actuarial calculations based on the mandated terms, to negotiate prices with those calculations in mind, and to walk away from an inadequate bargain. The insurer may also contract with employers to secure the appropriate standard by which its decisions interpreting the mandatory language will be reviewed. *Firestone Tire*, 489 U.S. at 115. By contrast, allowing the enforcement of state-law standards through state-law remedies—potentially including consequential and punitive damages in significant and unpredictable amounts—would effectively undo insurers' past pricing decisions and introduce a significant element of uncertainty into future actuarial calculations—an element of uncertainty that will likely produce much higher prices than the mere addition of the mandated benefit to the plan terms would cause.

2. Although employee welfare benefit plans offer varying types of benefits, from disability insurance to health coverage, and each of these plans imposes its own eligibility criteria, they are all subject to the same, nationally uniform set of remedies set out in ERISA. The statute leaves it to the

individual plan to tailor the eligibility criteria to fit the benefit at issue, subject to permissible state-law regulation of the benefits that a qualified insurer may or must offer. ERISA prescribes only the uniform remedy. It is precisely that uniformity that *Pilot Life* secured; the Fifth Circuit overlooked; and Davila's THCLA claims threaten to undermine. For this reason, even those who disagree with this Court's reading of ERISA's remedial provisions in cases like *Mertens*, and who sympathize with results like those reached by the court below, recognize that "opportunistic attacks on preemption" are not the appropriate means of achieving those results: disrupting the essential uniformity of Section 502(a)—even if misconstrued—would "serve mainly to complicate ERISA and to create anomalous results" for both beneficiaries and providers. *Cicio*, 321 F.3d at 107 (Calabresi, J., dissenting in part); *see also DiFelice*, 346 F.3d at 465-66 (Becker, J., concurring).[26] Even these critics recognize that their policy concerns should be addressed within ERISA's uniform federal framework. *See* U.S. Chamber Br. at 24.

That uniform framework would be undone, and the predictability and certainty secured by the *Pilot Life* line of decisions would be obliterated, by affirmance of the decision be-

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[26] Indeed, even the academic criticism cited in the *DiFelice* concurrence and the *Cicio* dissent directs little firepower in the direction of the core holding of *Pilot Life*, *i.e.*, that Section 502(a) is exclusive and preempts any disruption of that exclusivity. Rather, the law review articles cited by Judges Becker and Calabresi take aim primarily at this Court's decisions in *Mertens* and *Great-West*, in which this Court rejected plaintiffs' attempts to obtain monetary awards under the rubric of equitable relief. This case does not present a vehicle to reexamine those cases—not only has Davila not sought equitable relief under ERISA, he has sought a remedy, punitive damages, that even the critics of *Mertens* and *Great-West* do not think ERISA can be read to authorize—and no party has requested that this Court do so.

low. Because HMOs are *required* to have a medical professional available to review the denial of benefits based on medical necessity (*see* 29 C.F.R. § 2560.503-1(h)(3)(iii)), *any* such claim against an HMO can be characterized as based on a "mixed decision," as the Fifth Circuit construed that term. The inevitable, and immediate, consequence would be an increase in healthcare costs or a decrease in available coverage, and quite probably both. *See* U.S. Chamber Amicus Br. at 24-26. In the absence of any compelling legal or logical reason to depart from *Pilot Life*, this Court should refrain from delivering such an unwarranted shock to the American economy. Even if opponents of *Pilot Life* could show some policy reason for imposing greater liability on HMOs under state law—and Aetna submits they cannot—they should address that showing to Congress, not to this Court.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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UNITED STATES CODE

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT SECURITY PROGRAM

SUBCHAPTER 1—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B—REGULATORY PROVISIONS

* * * * *

§ 1133. Claims Procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

CODE OF FEDERAL REGULATIONS

TITLE 29—LABOR

CHAPTER XXV—EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT—Table of Contents

§ 2560.503-1. Claims procedure

(a) *Scope and purpose.* In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a

benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate,

the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) *Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) *Plans providing disability benefits.* The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) *Claim for benefits.* For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) *Timing of notification of benefit determination.* (1) *In general.* Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) *Group health plans.* In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) *Urgent care claims*. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) *Concurrent care decisions*. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the

adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) *Other claims*. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) *Pre-service claims*. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days,

provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension f time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) *Post-service claims*. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) *Disability claims*. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) *Calculating time periods*. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the

date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) *Manner and content of notification of benefit determination.* (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be

provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) *Appeal of adverse benefit determinations.* (1) *In general.* Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) *Full and fair review.* Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) *Group health plans.* The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made

the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) *Plans providing disability benefits*. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) *Timing of notification of benefit determination on review*. (1) *In general*. (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) *Group health plans*. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) *Urgent care claims*. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) *Pre-service claims*. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that

provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) *Post-service claims.* (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In

such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) *Disability claims.* (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting

following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) *Calculating time periods*. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) *Furnishing documents*. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) *Manner and content of notification of benefit determination on review*. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) *Preemption of State law.* (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(*l*) *Failure to establish and follow reasonable claims procedures.* In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall

be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) *Definitions.* The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1) (i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in

whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) *Apprenticeship plans.* This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) *Applicability dates.* (1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.

MEMBER MEDICATION FORMULARY GUIDE

January 2000

Aetna US Healthcare

INTRODUCTION

Aetna U.S. Healthcare's *Medication Formulary Guide* lists the "preferred" generic and brand-name medications available through your prescription drug benefit plan.* These medications are referred to as "formulary" medications.

It's important to note that other nonpreferred (nonformulary) medications not listed may also be covered under your prescription drug benefits. Please refer to your plan documents for details.

The Formulary Exclusions, Precertification and Step-Therapy lists apply to some benefit plans. Please refer to these sections of the *Formulary Guide* and to your plan documents for further information.

How are drugs selected for the Aetna U.S. Healthcare formulary (preferred drug list)?

Our goal is to provide a formulary that gives members access to quality medications. The FDA-approved brand-name and generic drugs chosen for our formulary are selected based on their safety, effectiveness and overall value.

When choosing drugs for our formulary, Aetna U.S. Healthcare's Pharmacy Quality Advisory Committee (PQAC) and Pharmacy and Therapeutics (P&T) Committee each meet regularly to review drugs that have been approved by the FDA. The PQAC reviews available literature and other clinical information, and provides qualitative comments re-

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* Some medications, such as oral contraceptives and infertiliy medications, may not be covered for all members. Please check your plan document for details.

garding the drugs being reviewed to the P&T Committee. The PQAC is comprised of participating providers in active clinical practice from a variety of specialties and from different locations in the United States.

After evaluating information from different sources, the P&T Committee places medications in one of three categories:

Category I—The drug represents an important therapeutic advance. These drugs are always included on the formulary.

Category II—The drug is clinically and therapeutically similar to other available products. These drugs are further reviewed by Aetna U.S. Healthcare for overall value.

Category III—The drug has significant disadvantages in safety or efficacy when compared to other similar products. These drugs are always excluded from the formulary.

Generic drugs are therapeutically equivalent to their brand-name counterparts. They contain the same active ingredients in the same amounts as the brand-name drug. Also, generic drugs undergo the same rigorous FDA quality and safety reviews as brand-name medications. As such, generics are effective, safe alternatives to brand-name medications.

In addition, using generic drugs may help lower your health care expenses. Under some Aetna U.S. Healthcare prescription drug benefit plans, members pay a lower-copayment if they choose generic drugs over brand-name medications, which means lower out-of-pocket costs for them.

Should I share this *Formulary Guide* with my physician?

Yes. We encourage you to share the *Formulary Guide* with your physicians and take it with you each time you visit them. The *Formulary Guide* helps you talk with your physician about medication alternatives, such as less expensive brand-name and generic drugs. Please ask your doctors to

consider the medications in your *Formulary Guide* when they prescribe medications for you.

What if I have questions?

If you have any further questions about the *Formulary Guide* or your prescription drug benefits, please call the Member Services number on your ID card. (TDD 800-501-9863 for hearing impaired members.) If you have questions about specific medications, please consult with your physician.

We wish you good health.

The medications listed in the Aetna U.S. Healthcare *Medication Formulary Guide* are subject to change without prior notification. If you have access to the Internet, you can obtain the most current version of the *Formulary Guide* through Aetna U.S. Healthcare's website: www.aetnaushc.com/products/rx/index.html.

THE AETNA U.S. HEALTHCARE FORMULARY

The following is a list of "preferred" medications that are covered under your pharmacy benefit plan.* Medications not listed may also be covered, depending on your plan design.

Please note that the dollar signs ($) listed next to the drugs provide comparative cost information to educate members who may not be familiar with the relative costs of sinilar medications.

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* Some medications, for example oral contraceptives, may only be covered if additional, optional coverage has been added to your standard prescription drug benefit plan. Please refer to your plan documents for further information.

Key

Bold = Brand name of drug
italics = Generic name of drug
* = Recommended generic substitution for brand-name drug
QL = Quantity limit for some benefit plans
PR = Precertification may apply
ST = Step-therapy may apply

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Muscle and Skeleton

OSTEOPOROSIS

$$$	**Didronel** *(etidronate)*
$$$	**Fosamax** *(alendronate sodium)*
$$$$$	**Skelid** *(tiludronate)* **PR**
$$$$$	**Acotonel** *(risedronate)* **PR**

PAIN AND INFLAMMATION

$	*ibuprofen* (strengths > 200 mg)*
$	*indeomethacin**
$	*piroxicam**
$	*naproxen**
$$	*salsalate**
$$	*sulindac**
$$	*fenoprofen**
$$	*meclofenamate**
$$$	*indomethacin SR**
$$$	*tolmetin**
$$$	*choline Mg trisalicylate**
$$$	*ketoprofen**
$$$$	*etodolac**
$$$$	*flurbiprofen**
$$$$$	*diclofenac**

$$$$$	**Celebrex** *(celecoxib)* **PR, ST**
$$$$$	**Vioxx** *(rofecoxib)* **PR, ST**

PAIN AND INFLAMMATION COMBINATION____

$$$$	**Arthrotec** *(diclofenac/misoprostol)*

ARTHRITIS _____

$	*sulfasalazine**
$$$	*hydroxychloroquine**
$$$$	**Cuprimine** *(penicillamine)*
$$$$	**Ridaura** *(auranofin)*
$$$$$$$	**Arava** *(leflunomide)*

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PRECERTIFICATION LIST

The following medications require precertification under most pharmacy benefit plans. Precertification helps encourage appropriate use of certain drugs in accordance with current medical literature, manufacturer recommendations and Food and Drug Administration (FDA) guidelines. The precertification requirement applies to medications that people are more likely to take inappropriately or use in amounts that exceed dosage or length of treatment recommendations. If precertification applies to your benefit plan, your doctor must contact the Pharmacy Management Precertification Unit to request prior authorization for the medication. If the request is approved, the drug will be covered.

The drugs requiring precertification are subject to change.

If you have questions about which pharmacy benefit plan you have or whether this list applies to you, please call the Member Services number on your ID card. (TDD 800-501-9863 for hearing impaired members.)

Note: Some HMO plans may cover injectable medications through the medical benefit.

Noninjectable Medications

Accolate *(zafirlukast)*

Accutane *(isotretinoin)*

Actonel *(risedronate)*

Adderall *(amphetamine-dextroamphetamine)* for members > 18 years old

Amerge *(naratriptan)* 1mg tabs > 27 per month, 2.5 mg tabs > 9 per month

Atacand *(candesartan)*

Avalide *(irbesartanlhctz)*

Avapro *(irbesartan)*

Avita *(tretionoin topical)* for members > 36 years old

Azopt *(brinzolamide)*

Caverject *(alprostadil)* > 6 per month

Celebrex *(celecoxib)*

Coreg *(carvedilol)*

Cosopt *(dorzolamide/timolol)*

Cozaar *(losartan)*

Cylert *(pemoline)* for members > 18 years old

DDAVP *(desmopressin) tabs, nasal* > 8 weeks of therapy

Desoxyn *(methamphetarnine)* for members > 18 years old

Dexedrine *(dextroamphetamine)* for members > 18 years old

Dextrostat *(dextroamphetamine)* for members > 18 years old)

Diflucan *(fluconazole)* single dose of 150 mg covered without precertification

Diovan *(valsartan)*

Diovan HCT *(valsartan/hctz)*

Estring *(estradiol)* > 1 per 90 days

Helidac *(bismuth subsalicylate, metronidazole, tetracycline)* > 14 per year

Hyzaar *(losartan/hctz)*

Imitrex *(sumatriptan)* nasal > 1 pkg of 6 bottles per month, 50 mg tabs > 27 per month, 25 mg tabs > 45 per month

Infertility Medications (if a covered benefit for the group)

Lamisil *(terbinafine tab)*

Maxalt *(rizatriptan)* 5 mg tabs > 24 per month, 10 mg tabs > 12 per month

Micardis *(telmisartan)*

Muse *(alprostadil)* > 6 per month

Prevpac *(amoxicillin, clarithromycin, lansoprazole)* > 14 per year

Retin-A/micro *(tretinoin topical)* for members > 36 years old

Rezulin *(troglitazone)*

Ritalin *(methylphenidate)* for members > 18 years old

Singulair *(montelukast)*

Skelid *(tiludronate)*

Sporanox *(itraconazole)*

Stadol NS *(butorphanol)* > 2 per month

Tritec *(ranitidine/bismuth citrate)* > 28 per year

Trusopt *(dorzolamide)*

Ultram *(tramadol)*

Vesanoid *(tretinoin)*

Vioxx *(rofecoxib)*

Wellbutrin SR *(bupropion)* 150 mg only

Zagam *(sparfloxacin)*

Zomig *(zolmitriptan)* 2.5 mg tabs > 18 per month, 5 mg tabs > 9 per month

Injectable Medications

Actimmune *(interferon gamma-1B)* for nonmalignancy

Alferon N *(interferon alfa-N3)* for nonmalignancy

Avonex *(interferon beta 1-A)*

Betaseron *(interferon beta 1-B)*

Ceredase *(alglucerase)*

Cerezyme *(imglucerase)*

Depo-Provera *(medroxyprogesterone)*

Epogen *(erythropoietin)*

Flolan *(epoprostenol)*

Growth Hormones (if a covered benefit for the group)

Humalog *(insulin lispro)*

Human Chorionic Gonadotropin

Hyalgan *(hyaluronate)*

Imitrex *(sumatriptan)* > 4 kits per month

Infergen *(interferon alfacon-1)* for nonmalignancy

Infertility Medications (if a covered benefit for the group)

Intravenous Immunoglobulin (IGIV, IGG)

Intron-A *(interferon alfa-2B)* for nonmalignancy

Lupron *(leuprolide)*

Procrit *(erythropoietin)*

Prolastin *(alpha-1-antitrypsin)*

Roferon-A *(interferon alfa-2A)* for nonmalignancy

Synvisc *(hyaluronate)*

Zoladex *(goserelin)*

FOR CALIFORNIA ONLY: all self-injectable drugs require precertification.

* * * *

STEP-THERAPY LIST

Drugs on the Step-Therapy List are subject to a different form of Precertification requirement under most pharmacy benefit plans. If step-therapy applies to your benefit plan, you must try one or more "prerequisite therapy" medications before a "step-therapy" medication will be covered. However, if it is medically necessary for you to be initially treated with a step-therapy medication, your doctor can contact the Pharmacy Management Precertification Unit to request coverage as a medical exception. If the request is approved, the drug will be covered.

For example, Zestril is a step-therapy medication that requires one prerequisite therapy medication. Zestril will not be covered under most benefit plans unless Prinivil has first been tried. However, if it is medically necessary for you to be treated with Zestril, your doctor can contact the Pharmacy Management Precertification Unit to request coverage.

Axid is a step-therapy medication that requires two prerequisite therapy medications. Axid will not be covered under most benefit plans unless cimetidine and ranitidine have each been tried. However, if it is medically necessary for you to be treated with Axid, your doctor can contact the Pharmacy Management Precertification Unit to request coverage.

The drugs on the Step-Therapy List are subject to change.

If you have questions about which pharmacy benefit plan you have or whether this list applies to you, please call the Member Services number on your ID card. (TDD 800-501-9863 for hearing impaired members.)

Step-Therapy Medications	Prerequisate Therapy
Accolate *(zafirlukast)*	any inhaled antiinflammatory agent (e.g. **Pulmicort, Flovent, Vanceril/DS, Azmacort**); and an inhaled bronchodilator (e.g. *albuterol,* **Tornalate, Alupent, Proventil HFA**, *ipratropium,* **Atrovent, Combivent, Maxair**)
Alora *(estradiol patch)*	any oral estrogen (e.g: *estradiol, estropipate,* **Estratab, Premphase, Prempro, Premarin**); and **Estraderm**; and **Vivelle/DOT**
Amaryl *(glimepiride)*	any generic oral hypoglycemic (e.g. *tolazamide, tolbutamide, glipizide, glyburide, chlorpropamide, acetohexamide)*
Atacand *(candesartan)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril**); and **Cozaar**, and **Diovan**
Avalide *(irbesartan/hctz)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril**); and **Hyzaar**, and **Diovan HCT**
Avapro *(irbesartan)*	any angiotensin converting enzyme inhibitor (e.g, *captopril,* **Prinivil, Accupril**); and **Cozaar**, and **Diovan**
Axid *(nizatidine)*	*cimetidine;* and *ranitidine*

Azopt *(brinzolamide)*	any ophthalmic beta blocker (e.g. *levobunolol, timolol,* **Ocupress, Betimol, Betoptic-S)**
Baycol *(cerivastatin)*	maximum doses of **Lescol** and/or **Zocor**
Celebrex *(celecoxib)*	any two generic NSAIDs (e.g. *ibuprofen, naproxen, salsalate, choline MG trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac, diclofenac, ketoprofen, flurbiprofen)*
Climara *(estradiol patch)*	any oral estrogen (e.g., *estradiol, estropipate,* **Estratab**; **Premphase, Prempro, Premarin**); and **Estraderm**, and **Vivelle/DOT**
CombiPatch *(estradiol patch/norethindrone)*	any oral estrogen (e.g., *estradiol, estropipate,* **Estratab**; **Premphase, Prempro, Premarin**); and **Estraderm**, and **Vivelle/DOT**
Coreg *(carvedilol)*	**Lanoxin** and any angiotensin coverting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril)**
Cosopt *(dorzolamide/ timolol)*	any ophthalmic beta blocker (e.g. *levobunolol, timolol,* **Ocupress, Betimol, Betoptic-S**); and **Azopt**
Cozaar *(losartan)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril)**

Daypro *(oxaprozin)*	any two generic NSAIDs (e.g. *ibuprofen, naproxen, salsalate, choline MG trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac, diclofenac, ketoprofen, flurbiprofen)*
Diovan *(valsartan)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril)**
Diovan HCT *(valsartan/hctz)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril)**
Estraderm *(estradiol patch)*	any oral estrogen (e.g. *estradiol, estropipate,* **Estratab, Premphase, Prempro, Premarin)**
FemPatch *(estradiol patch)*	any oral estrogen (e.g. *estradiol, estropipate,* **Estratab, Premphase, Prempro, Premarin**); and **Estraderm**; and **Vivelle/DOT**
Glucophage *(metformin)*	any generic oral hypoglycemic (e.g. *tolazamide, tolbutamide, glipizide, glyburide, chlorpropamide, acetohexamide)*
Hyzaar *(losartan/hctz)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril)**
Lexxel *(enalapril/ felodipine)*	any single agent formulary ACE inhibitor or Calcium Channel Blocker; and **Lotrel**
Lipitor *(atorvastatin)*	maximum doses of **Lescol** and/or **Zocor**

Lodine XL *(etodolac)*	any two generic NSAIDS (e.g. *ibuprofen, naproxen, salsalate, choline Mg trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac; diclofenac, ketoprofen, flurbiprofen)*
Lotrel *(amlodipine/ benazapril)*	any single agent formulary ACE inhibitor or Calcium Channel Blocker
Mevacor *(lovastatin)*	maximum doses of **Lescol** and/or **Zocor**
Micardis *(telmisartan)*	any angiotensin converting enzyme inhibitor (e.g. *captopril,* **Prinivil, Accupril**); and **Cozaar**; and **Diovan**
Pepcid *(famotidine)*	*cimetidine;* and *ranitidine*
Prandin *(repaglinide)*	any generic oral hypoglycemic (e.g. *tolazamide, tolbutamide, glipizide, glyburide, chlorpropamide, acetohexamide)*
Pravachol *(pravastatin)*	maximum doses of **Lescol** and/or **Zocor**
Precose *(acarbose)*	any generic oral hypoglycemic (e.g. *tolazamide, tolbutamide, glipizide, glyburide, chlorpropamide, acetohexamide)*

Relafen *(nabumetone)*	any two generic NSAIDS (e.g. *ibuprofen, naproxen, salsalate, choline Mg trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac, diclofenac, ketoprofen, flurbiprofen)*
Rezulin *(troglitazone)*	any generic oral hypoglycemic (e.g. *tolazamide, tolbutamide, glipizide, glyburide, chlorpropamide, acetohexamide)*
Singulair *(montelukast)*	any inhaled anti-inflammatory agent (e.g. **Pulmicort, Flovent, Vanceril/DS, Azmacort**); and an inhaled bronchodilator (e.g. *albuterol,* **Tornalate, Alupent, Proventil HFA,** *ipratropium,* **Atrovent, Combivent, Maxair**)
Tagamet *(cimetidine)*	*cimetidine*
Tarka *(trandolapril/ verapamil)*	any single agent formulary ACE inhibitor or Calcium Channel Blocker; and **Lotrel**
Teczem *(diltiazem/enalapril)*	any single agent formulary ACE inhibitor or Calcium Channel Blocker; and **Lotrel**
Trusopt *(dorzolamide)*	any ophthalmic beta blocker (e.g. *levobunolol, timolol,* **Ocupress, Betimol, Betoptic-S**); and **Azopt**

Vioxx *(rofecoxib)*	any two generic NSAIDS (e.g. *ibuprofen, naproxen, salsalate, choline Mg trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac, diclofenac, ketoprofen, flurbiprofen)*
Vivelle/DOT (*estradiol patch)*	any oral estrogen (e.g. *estradiol, estropipate,* **Estratab, Premphase, Prempra, Premarin**)
Voltaren XR *(diclofenac sodium)*	any two generic NSAIDS (e.g. *ibuprofen, naproxen, salsalate, choline Mg trisalicylate, piroxicam, sulindac, fenoprofen, meclofenamate, tolmetin, etodolac, diclofenac, ketoprofen, flurbiprofen)*
Zantac *(ranrtidine)*	*ranitidine*
Zestril *(lisinopril)*	**Prinivil** *(lisinopril)*

* * * *

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Nos. 02-1845 and 03-83

Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

No. 02-1845

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

No. 03-83

CIGNA HEALTHCARE OF TEXAS, INC. and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTION PRESENTED

Whether Texas statutory HMO medical-malpractice claims by two patient-insureds who followed their HMOs' defective medical-necessity decisions are not just preempted, but "completely preempted" so that the state-court claims are removable to federal court?

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STATEMENT OF THE TWO CASES

A. The Texas Act.

Fundamental changes in the delivery of health care over the last 20 years led Texas to enact the 1997 Texas Health Care Liability Act (the "Texas Act"), which regulates health-insurance carriers, health-maintenance organizations (HMOs), and managed-care entities. Tex. Civ. Prac. & Rem. Code, §§ 88.001-003 (Resp't App. E; *also at* Aetna Pet. App. 56a-63a). Among other things, the Texas Act requires HMOs and other managed-care entities to exercise ordinary care when making health-care-treatment decisions that control or influence the course of treatment. Sec. 88.002(a).[1] Texas also delineated in the Act's first paragraph a definition of "[a]ppropriate and medically necessary" as what is "determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community." Sec. 88.001(1). That standard is reflected in § 88.001(10), which requires employees and agents of HMOs and managed-care entities, such as pharmacists, discharge nurses, and medical directors, to exercise the degree of care that a "person of ordinary prudence in the same profession, specialty, or area of practice" would apply. With this Act, Texas exercised its historic police power in two traditional areas of state regulation: protecting the health and safety of its citizens and regulating insurance.[2]

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1. A "[h]ealth care treatment decision" means "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Sec. 88.001(5).

2. In 1837, even before statehood, Dr. Anson Jones wrote for the Republic of Texas one of the earliest medical-practice acts. *See* Board of Medical Examiners' History, available at Texas State Board of Medical Examiners' website, www.tsbme.state.tx.us/boards/mbhis.htm.

As this Court noted in *Pegram v. Herdrich*, 530 U.S. 211, 220 (2000), "many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines"; when an HMO receives a fixed sum to care for a group of individuals, every dollar paid out for care has an adverse effect on the company's finances. Texas chose to prevent potential abuse by insisting that HMOs and their professional decision-makers provide a minimum level of treatment: a professional medical standard of ordinary care.

Petitioners acknowledge that a state may regulate HMO medical-necessity decisions without running afoul of ERISA by imposing independent review when the patient (or doctor) and the HMO continue to disagree. The Texas legislature and then-Governor George W. Bush made a policy decision also to address another frequent problem: where instead of ignoring or opposing the HMO's medical-necessity decision, the patient-insured follows the course of treatment charted—and in many instances controlled—by his or her HMO, and the HMO's decision ends up being a medically imprudent one that causes significant harm.

The duty imposed by the Texas statute exists and operates exclusive of, regardless of, and without reference to or connection with the existence or operation of any ERISA plan. The Texas Act is unconcerned with the reason an HMO makes a medical decision directly affecting treatment—only that it does. An entity is liable under the Act if it fails to use reasonable care in deciding whether a requested treatment is medically necessary. A complaint under the Act need not allege that the HMO violated the terms of any contract; the complaints in this case contain no such allegation. Relief under the Act is limited to remedies for injuries caused by medical malpractice.

B. Utilization review and medical necessity.

Both Aetna and CIGNA were performing prospective or concurrent medical-necessity utilization review. At the time ERISA was enacted, medical-necessity utilization review was done, if at all, retrospectively. *See* R. Rosenblatt, S. Law, & S. Rosenbaum, Law and the American Health Care System 212 (1997) ("Rosenblatt") ("Prior to the late 1970s, private and public insurance plans rarely used the medical necessity . . . criteria to question the treating physician's judgment."). Beginning in the late 1970s and early 1980s, managed-care entities began performing medical-necessity reviews prospectively or concurrently. Providers and patients were required to obtain the HMO's approval before or during treatment. *See Pegram*, 530 U.S. at 219.

Through their contracts with providers, HMOs often require that doctors, hospitals, and pharmacies in their provider networks "comply" or "cooperate" with the HMO's medical-necessity decisions.[3] In part, because the providers involved, whether hospital or physician, are sometimes pre-paid by capitation (a fixed sum for all members, sick or not, paid per member per month), the medical-necessity decision is not even necessarily one about payment. In many instances the hospital or other provider may refuse to provide the treatment until the HMO gives the green light; the HMO might instead require an alternative, less expensive (although possibly less efficacious, or more dangerous) form of treatment.

The only reason for performing utilization review prospectively or concurrently is to influence the course of treatment after the insured-against peril or "hazard" has

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3. Resp't App. A and B (examples of CIGNA and Aetna provider contracts, all requiring the providers to so comply or cooperate). *See also* CIGNA Br. 26; Rosenblatt at 559 ("[n]etwork exclusion represents a potentially powerful tool for ensuring compliance with coverage and utilization review standards and guidelines.").

become imminent.[4] Texas law does not, of course, prohibit prospective or concurrent review—liability accrues only if the HMO's decision violates the statutory standard of care. CIGNA candidly concedes that its medical-necessity decisions are "imbued with *medical* judgment," CIGNA Br. 7 (emphasis added); Aetna is less forthcoming about whether it considers its medical-necessity decisions to entail the exercise of professional medical judgment.

Texas concluded that traditional malpractice law—which applied only to the physician or other medical personnel who actually provide treatment—accorded little real protection to a patient whose treatment was in practice being shaped, not by his or her doctor, but by the entity engaging in utilization review. The Texas Act therefore defined the "treatment decision[s]" subject to the duty of care (and thus malpractice liability) to include any decision "which *affects* the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Sec. 88.001(5) (emphasis added). The practical effect of this pivotal definition was to extend the protections of state malpractice standards to patients (such as Respondents) whose treatment was being shaped by HMOs and other entities through utilization

4. *See* Rosenblatt at 215, 1011; J. Scott Andresen, *Is Utilization Review the Practice of Medicine?* 19 J. of Legal Med. 431, 435 (Sept. 1998); United States General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* 2 (July 1998) (GAO/HEHS-98-154). The insurance term "hazard" comes from the Arab name given to ancient dice games—"al zahar." Peter L. Bernstein, Against the Gods—The Remarkable Story of Risk 12-13 (Wiley & Sons 1998). In indemnity (fee-for-service) insurance, the health insurer bets on the roll of the dice, spreading the risk or hazard that, say, 2 or 12 will come up among a number of insureds, paying those who become ill (those rolling 2 or 12). In a managed-care environment, the HMO toys with the dice *after* the roll when it performs medical-necessity review after a 2 or 12 has been rolled and the patient needs care, by trying to modulate the roll's outcome—by influencing the treatment provided.

review. These cases involve two patients who adhered to the course of treatment charted by their HMOs' medical-necessity decisions. When those decisions proved not to meet Texas's professional medical standard for an HMO, the two patients availed themselves of the Texas Act.

C. CIGNA's actions that affected Ruby Calad's treatment.

Ruby Calad was prematurely forced out of the hospital by CIGNA's discharge nurse, contrary to her doctor's medical judgment, following a complicated hysterectomy with rectal, bladder and vaginal repair. CIGNA precertified Calad for only a one-day post-surgery hospital stay (CIGNA 5th Cir. Br. 3); CIGNA's discharge nurse made a second, concurrent decision on the day Calad was discharged that continued hospitalization did not meet CIGNA's medical-necessity criteria. Calad's physical condition post-anaesthetic and her financial condition did not make days of appeal feasible. (The quickest appeal process now available under federal law is 72 hours. 29 C.F.R. § 2560.503-1(f)(2)(i).) Serious physical complications after she was home—which likely could have been avoided had she been allowed to recover a few more days in the hospital—required her emergency re-admission to the hospital a few days later. J.A. 185.

Calad's complaint alleged that the CIGNA nurse's actions did not meet the Texas Act standard of care, and that CIGNA influenced and controlled the course of treatment that Calad experienced. J.A. 180-87. The complaint did not seek any award of benefits (J.A. 188); since Calad had not remained in the hospital for additional recovery days, she had no such expenses to reimburse. Instead, Calad sought the only form of relief that could then redress CIGNA's violation of the medical standard imposed by the Texas Act. J.A. 188.

D. Aetna's actions that affected Juan Davila's treatment.

Juan Davila has severe rheumatoid arthritis post-polio and was a member of Aetna's HMO, which is not itself an "ERISA plan." His treating physician made a medical decision that Davila should have his constant pain treated with Vioxx, which indisputably is on Aetna's formulary—the list of drugs Aetna decided it would provide to all members. Aetna makes its own determinations, at any time and without notice, about the medications listed in its drug formulary, with no guidelines from or consultation with an ERISA-plan sponsor. Aetna App. 28a, 30a, 34a.[5] The formulary documentation never appeared in the record below as part of what Aetna described as the "ERISA plan" documents. The formulary attached to Aetna's brief shows Davila could get Vioxx only by first experiencing significant harm from two other types of medicine unless Aetna made a medical-necessity decision otherwise. The letter spelling out this directive was signed by an Aetna pharmacist. Aetna Pet. App. 81a.

Aetna insisted, as a medical-necessity decision, that Davila first receive a generic substitute for Vioxx that had a much higher risk of gastrointestinal toxicity and bleeding. Aetna Pet. App. 67a, 76a-77a. Although the formulary documentation states that "[g]eneric drugs are therapeutically equivalent to their brand-name counterparts," and that "generics are effective, safe alternatives to brand-name medications," Aetna App. 27a, the medical literature shows that not to be the case with regard to Vioxx. Aetna Pet. App. 76a-77a. And contrary to Aetna's inference that Davila chose not to pay for Vioxx, he could not even get his pharmacy to fill the prescription. Aetna Pet. App. 67a.

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5. An employer can exclude its employees from Aetna's formulary altogether, or exclude the availability of certain classes of drugs, but no ERISA-plan administrator or sponsor determines which drugs go into Aetna's formulary or how its step program will work. Aetna App. 26a-28a, 34a.

Davila took the generic drug Aetna insisted he try first, but after a few weeks began to experience weakness and related symptoms. He was rushed to the emergency room, where he was given seven units of blood; doctors there told him that he was within hours of dying from internal bleeding—bleeding that Davila contends was the result of Aetna's medical decision. Aetna Pet. App. 68a, 77a-78a. Five days in critical care and a readmission later, Davila now cannot take any pain medication, including Vioxx, that is absorbed through the stomach.

Davila sued under the Texas Act, alleging that Aetna had engaged in treatment-influencing medical malpractice under the Texas Act by "directly influenc[ing] and controll[ing]" his medical treatment, and that Aetna had violated the Texas Act duty of ordinary care when it insisted on the use of a cheaper alternative to Vioxx. Aetna Pet. App. 65a-69a. The complaint expressly did not "seek recovery for denial of any benefits, nor . . . payment for Vioxx," Aetna Pet. App. 70a, nor did it assert that Aetna failed to pay for the Naprosyn (which caused his injuries) or seek pre-approval for Vioxx (which he is now too seriously injured to use). No claim was made of any ERISA plan violation.

E. District court proceedings.

Because neither Calad nor Davila had pleaded an ERISA claim, and because no federal claim was apparent from the face of the state-law complaints, Petitioners submitted extensive documentation upon removing to support their defense that an ERISA plan existed and that somehow the medical decisions complained of were really only administrative determinations. In district court, Petitioners sought to cast themselves in the role of ERISA fiduciaries, though CIGNA now equivocates about whether its utilization-review discharge nurse was acting as an ERISA fiduciary administering a plan. CIGNA Br. 36 n.6 (nurse "may or may not have been" an ERISA fiduciary). Aetna now maintains that its fiduciary status is irrelevant. Aetna Br. 32 n.15.

In Calad's case, CIGNA never issued an adverse benefit determination (a formal "denial"); it did not need to do so, since Calad did what CIGNA wanted by leaving the hospital early. Davila never received any "denial" letter; Aetna wrote only to his treating physician. Aetna Pet. App. 80a-81a. Davila knew only that his HMO wanted him to have a cheaper generic drug, and that his pharmacy would not fill his Vioxx prescription. These two cases demonstrate the more frequent reality of HMO medical decision-making: Given a choice between two treatment options, the HMO's medical-necessity decisions will often assure that a patient receives the course of treatment selected by the HMO.

Despite Petitioners' argument that Calad's and Davila's claims were in essence § 502(a)(1)(B) actions, so that complete preemption supported removal, both district courts dismissed Respondents' cases after Calad and Davila expressly declined to replead to assert any ERISA claim under § 502(a). The district courts' rulings raise a puzzling anomaly: on the one hand, the courts found that regardless of how Calad and Davila pleaded their respective cases, the claims were ones under § 502 and thus could not be remanded. But on the other hand, the courts then *dismissed* what they had held were ERISA claims, maintainable only in federal court, because Respondents had not pleaded any ERISA claim. CIGNA Pet. App. 40a; Aetna Pet. App. 34a-35a. Petitioners each agreed, in their briefing to the Fifth Circuit, that neither Respondent had pleaded a claim for § 502(a)(1)(B) benefits. *See* Aetna 5th Cir. Br. 13; CIGNA 5th Cir. Br. 26, 29. Because Calad and Davila did as their HMOs medically decided, and because these cases are about HMO medical malpractice, Respondents have consistently contended they had no § 502 claim to bring.

F. *Pegram*, the Fifth Circuit opinion below, and *Rush Prudential.*

The Fifth Circuit analyzed the substance of the claims and recognized that there was no § 502(a)(1)(B) claim that Respondents conceivably could have brought. Aetna Pet. App. 16a. This Court held in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that HMOs making determinations with both a medical-treatment and an eligibility aspect are not ERISA fiduciaries, and expressed "doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231. Acknowledging that allowing the plaintiff's claims for breach of ERISA fiduciary duty would have meant recognizing federal preemption of state regulation of HMO medical decisions, the Court noted that prior authority (holding that ERISA does not preempt a subject of traditional state regulation, such as the field of health care, without a clear manifestation of congressional purpose) "throws some cold water on the preemption theory." *Id.* at 237 (citing *New York State Conference of Blue Cross & Blue Shield Plans, Inc. v. Travelers Ins. Co.*, 514 U.S. 645 (1995)) ("*Travelers*").

The Fifth Circuit relied on *Pegram* to conclude that it seemed "beyond dispute that Calad's and Davila's claims involve such mixed decisions," and that Respondents could not have asserted an ERISA breach-of-fiduciary-duty claim against Aetna or CIGNA. Aetna Pet. App. 13a-14a. After looking at the substance of Respondents' claims—and not merely the remedy, as Petitioners maintain—the Fifth Circuit also concluded that "[b]ecause the [Texas Act] does not provide an action for collecting benefits, it is not [completely] preempted by § 502(a)(1)(B) under *Pilot Life* [*Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987)]." Aetna Pet. App. 20a. Any doubts about that holding, the court noted, "are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice." *Id.*

After both cases had been briefed and argued below, this Court issued its opinion in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), holding for the first time that states could properly regulate HMO medical-necessity decision-making without running afoul of ERISA's express preemption provision, by virtue of the insurance saving clause, 29 U.S.C. § 1144(b)(2)(A). That core holding bears directly on the Texas Act, because the Act's regulation of HMO medical-necessity decisions was found to be regulation of insurance within the saving clause on remand from this Court in light of *Rush Prudential*. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 314 F.3d 784 (5th Cir. 2002) ("*Corporate Health III*") (upholding the IRO provisions in a suit brought by Aetna). The Fifth Circuit had earlier upheld the Texas Act's liability provisions in certain respects as not relating to ERISA plans in the first place, a holding no party appealed. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir.) ("*Corporate Health I*"), *reh'g denied*, 220 F.3d 641, 643 n.5 (5th Cir. 2000) ("*Corporate Health II*"), *vacated on other grounds sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935 (2002)).

In the decision below, the Fifth Circuit "gleaned" that *Rush Prudential* narrowed implied complete preemption to a rule that "States may not duplicate the causes of action listed in ERISA § 502(a)" to allow participants to obtain remedies that Congress rejected. The Fifth Circuit recognized that the only case after *Pilot Life* and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), in which implied preemption has been applied was *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), where a general state tort law (not an insurance law) duplicated the elements of a substantive claim under ERISA and thus improperly expanded the available remedies from equitable relief to money damages. Aetna Pet. App. 19a-20a (quoting *Rush Prudential*'s description of *Ingersoll-Rand*).

The Fifth Circuit declined to rehear these cases *en banc*; Aetna and CIGNA then successfully petitioned for a writ of certiorari.

SUMMARY OF THE ARGUMENT

These are two medical-malpractice actions under the Texas Act. Based on unassailable principles of federalism, a state is presumptively able to regulate in the areas of its citizens' health and safety, and insurance, as Texas has done here. When that state regulation is said to collide with ERISA in such a way as to create removal jurisdiction, the *conduct* upon which the state, in exercising its police powers, has legislatively placed limits must be compared with the federal enactment to see if the latter manifests any clear congressional intent to replace state law with a substantively comparable means of redressing that harm. The Court finds implied complete preemption only where a state claim involves a matter of central concern to the federal scheme, and where the federal act creates a cause of action to replace the purportedly preempted state claim. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25-26 (1983); *see also Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2063 (2003). State-law medical-malpractice claims find neither counterpart in ERISA, particularly (but not only) because managed-care entities such as Aetna and CIGNA do not function as ERISA fiduciaries in making medical-necessity decisions. *See Pegram*, 530 U.S. at 231.

Petitioner's Questions Presented frame the issue in terms of judicially implied ERISA § 502(a) complete preemption creating removal jurisdiction. Calad and Davila address that issue first within the argument, and show that even if Petitioners have a § 514(a) conflict preemption *defense*, Respondents' Texas Act claims are not removable under § 502(a). But because Congress included in ERISA an express preemption clause with significant explicit exceptions it is necessary also to examine the plain text of those provisions, an approach consistent with this Court's precedents. In such

cases as *Ingersoll-Rand*, *Taylor*, and *Pilot Life*, the Court recognized § 502 preemption of claims that were also preempted by § 514(a), but never has it implied § 502 complete preemption *without* concomitant § 514(a) preemption. In the absence of § 514(a) express preemption, preemption solely under § 502 should not be lightly implied, if at all, particularly since § 502(a)(1)(B)'s enforcement provisions apply only to ERISA plans and ERISA fiduciaries. With § 514(a), Congress specified the circumstances in which ERISA will "supersede . . . State laws," and expressly limited the statutory preemption provision to "State laws insofar as they . . . relate to an employee benefit plan." Congress's decision not to preempt state laws that do not "relate to" an ERISA plan should control.

ERISA § 514(a) does not preempt a Texas Act medical-malpractice claim, a cause of action not dependent on an ERISA plan's existence. So after first examining complete-preemption principles under § 502 and analogous federal law from which § 502 complete preemption was derived, Respondents then show that no § 514(a) conflict preemption exists in the first place and, alternatively, that no preemption exists due to ERISA's insurance saving clause and the related federal-law exception. Section 514(b)(2)(A) saves from ERISA preemption any state law that "regulates insurance." That exemption applies to both § 502 and § 514(a) preemption; the insurance saving clause provides that "nothing in this subchapter," a formulation broader than just "nothing in § 514," will preempt state insurance regulation, and the Texas Act is a regulation of insurance for reasons identical to the Illinois statute involved in *Rush Prudential*. Respondents then return to § 502 to address Petitioners' tacit but essential argument that judicially implied complete preemption should overcome an express congressional statement of no preemption.

These cases do not involve adding a remedy to the ERISA armament; they involve medical misconduct that takes place

outside ERISA's furthest reaches. The very nature of medical errors is such that ERISA protections and remedies are irrelevant. Davila could not seek reimbursement, under ERISA or otherwise, for purchasing Vioxx out of pocket (he never bought any), or approval of future Vioxx prescriptions (he is now too sick to use it). Calad could not seek reimbursement for additional hospital days in 1999 (she did not stay longer than CIGNA said she could stay), and it was a moot point at the time she sued in 2000.

Petitioners' central contention is that there was some earlier point in time when Calad and Davila could, or should, have brought a § 502 claim for benefits. Respondents disagree; however, if a § 502 claim was appropriate at some point in time, that window of time was exceptionally brief. Calad might have sued for benefits only for a few hours after she learned of the CIGNA nurse's discharge decision and before she left the hospital. Davila might have sued only during the approximately 24-hour period between when he was denied Vioxx and when he began to take Naprosyn to relieve his severe pain. Instead, however, Respondents followed the course of treatment charted by their HMOs' medical-necessity decisions, exactly as CIGNA and Aetna intended.

By their insistence that § 502 contain the sole remedy, Petitioners overlook the natural question: Remedy *for what*? Here, one must look at the substance of the conduct at issue—medical decisions made under the rubric of "medical necessity," which if done in violation of the state medical standard of ordinary care result in liability—to see that the state-law remedy *and* the underlying substantive claim differ materially from those under ERISA. What Petitioners postulate is that if the remedy *resembles* a § 502 claim, the HMO wins, and can remove; if the state remedy *differs* from the § 502 remedy (as any state remedy almost always will), even though ERISA does not regulate the substantive conduct the HMO will still win. This was not Congress's intent.

That ERISA has no meaning in cases involving medical-judgment errors carries over into the Department of Labor's

recent regulations on appealing health insurers' decisions. 29 C.F.R. § 2560.503-1 (2002). The Department has consistently recognized ERISA's practical limits in the area of managed-care medical decisions, having not only filed numerous *amicus* briefs urging no preemption of state malpractice actions against HMOs, but having also enshrined that position in the Federal Register, in which it explained that its new appeal procedures did not "limit a claimant's ability to pursue any state law remedy that may be available as a result of a medical decision, even where such decision implicates eligibility for benefits under a plan. *See Pegram* [full citation omitted]." 65 Fed. Reg. 70246, 70254 n.34 (Nov. 21, 2000).

With its holding that HMOs do not act as ERISA fiduciaries when making "mixed" treatment and eligibility decisions, and that Congress did not intend to federalize state malpractice law, *Pegram* extends the principles first announced in *Travelers* by plainly reiterating that state law continues to control malpractice cases even where an HMO's decision has a coverage component.

Pegram expressly considered the interplay between ERISA and the Federal HMO Act of 1973; the legislative history of both § 514(a) and the HMO Act establishes that Congress meant to (and did) leave HMO quality-of-care matters to the states. While the Federal HMO Act has not received the litigation attention that ERISA has enjoyed over the years, that Act is an independent and equally fundamental force in the overall design of modern federal health-care policy; it clearly empowers the states to oversee and maintain HMO health-care quality. With the Federal HMO Act, Congress deliberately rejected the *national* quality-health-care commission prominently featured throughout early proposals and in the legislative history, ultimately concluding that the states were better suited to regulate HMO quality-of-care issues.

More fundamentally, this Court has never held that judicially implied preemption can contradict or overrule express congressional language precluding preemption. Under *Rush Prudential*, a decision not handed down until after oral argument in the cases below, Texas's regulation of HMO medical-necessity decisions falls within both the ERISA clause saving state insurance regulation from preemption, 29 U.S.C. § 1144(b)(2)(A), and the McCarran-Ferguson Act, 15 U.S.C. § 1012 (reserving the regulation of the business of insurance to the states). Even mere (defensive) conflict preemption overrides a saving clause only where state law prevents or frustrates the accomplishment of an explicit federal objective, or where it is impossible for a party to comply with both federal and state law—prerequisites absent from these cases. Section 502 implied preemption cannot trump the express exceptions to preemption made plain in § 514, both in the insurance saving clause and the federal-law exception, 29 U.S.C. § 1144(d), which incorporates and reinforces the McCarran-Ferguson Act. In its *amicus* brief in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), the United States agreed that § 502 implied preemption cannot overcome § 514's specific insurance saving clause. Respondents' claims are not preempted for this reason.

Petitioners' policy-based arguments concerning "uniformity," the HMOs' "settled expectations" of immunity from poor medical-necessity decisions, and cost considerations are belied by (among other things) the disuniformity of thousands of medical-necessity definitions applied by the various HMOs and utilization-review entities, and by objective studies showing that costs would not increase if the confusion over ERISA preemption is squarely put to rest.

The Court can accommodate both federalism concerns and the *Pilot Life/Taylor* rule by holding one of three things:

(1) ERISA does not preempt state regulation of health-care matters such as the Texas Act; (2) the insurance saving clause applies to the Texas Act under *Rush Prudential* and is not trumped by judicially implied preemption; or (3) state-court medical-malpractice claims against an HMO, even if they might be subject to a preemption defense, are not removable because they do not arise under federal law. The judgment below should be affirmed.

ARGUMENT

I. Given key principles of judicially implied complete preemption, *Franchise Tax Board* governs, and *Pilot Life* and *Taylor* should not be extended to HMO medical decisions, especially when the patient followed the HMO's incorrect medical-necessity decision.

Calad and Davila did exactly what their HMOs wanted them to do—acquiescing in the HMOs' medical-necessity decisions without seeking injunctive relief or paying for care out of pocket (assuming either was even possible) and then seeking reimbursement. When the resulting harm manifested itself, their Texas Act claims offered the only available relief, with no implication of ERISA benefits whatsoever. Aetna's and CIGNA's position rests upon an uncritical assumption that a § 502 claim for ongoing denial of financial benefits owed through an ERISA plan, such as *Pilot Life* and *Taylor* involved, is conceptually identical to a state-law claim for an HMO's past substandard medical-necessity decision. But this Court has never extended ERISA's remedial provisions beyond the confines of a plan participant's efforts to recover accrued financial benefits that were being wrongfully withheld, and has no reason to do so now. When *Pilot Life* and its progeny are properly considered under well-established preemption principles, any extension of the *Pilot Life/Taylor* rule to subsume state medical-malpractice actions is unwarranted.

A. The long-standing and formidable presumption against preemption; the Texas statute regulates medical health and safety matters, traditionally the domain of the states.

The Texas statute must be viewed in light of the Court's long history of applying a presumption against preemption of state law, especially where, as here, that state law deals with its citizens' health and safety. Analyzing the extent of congressional intrusion upon matters traditionally within state control starts with the assumption that a federal act does not supersede the states' historic police powers unless that was Congress's clear and manifest purpose. *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). And preemption of such matters "should not lightly be inferred." *Hawaiian Airlines, Inc. v. Norris*, 512 U.S. 246, 252 (1994) (quotation omitted).

Calad's and Davila's state-law statutory claims find no substitute whatever in ERISA's substantive or remedial provisions; the claims implicate general health-care issues, something the Court has repeatedly found to be the traditional province of state regulation. *Rush Prudential*, 536 U.S. at 387 (describing "reasonable medical care" as involving "quintessentially state-law standards"); *Pegram*, 530 U.S. at 237 (noting that the "field of health care" is "a subject of traditional state regulation"); *De Buono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) ("the historic police powers of the State include the regulation of matters of health and safety"); *Travelers*, 514 U.S. at 661 ("nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern"); *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (noting "presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause").

The Court treads only lightly upon "the constitutional role of the States as sovereign entities," *Alden v. Maine*, 527 U.S. 706, 713 (1999), recognizing that the federal government's power to impose its will on the states under the Supremacy Clause "is an extraordinary power in a federalist system." *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991); *see also Younger v. Harris*, 401 U.S. 37, 44 (1971) (states have legitimate interests that the federal government is bound to respect even though its laws are supreme). For this reason, "those charged with the duty of legislating [must be] reasonably explicit." Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 Colum. L. Rev. 527, 539-40 (1947), *quoted in BFP v. Resolution Trust Corp.*, 511 U.S. 531, 544 (1994). *See also Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 588 (1985) (O'Connor, J., dissenting) ("the autonomy of a State is an essential component of federalism"; if state autonomy is ignored, "federalism becomes irrelevant simply because the set of activities remaining beyond the reach of such a commerce power 'may well be negligible'" (internal citation omitted)). The Framers made clear that "[t]he powers reserved to the several States will extend to all the objects, which, in the ordinary course of affairs, concern the lives, liberties and properties of the people; and the internal order, improvement, and prosperity of the State." The Federalist No. 45, at 313 (James Madison) (J. Cooke ed. 1961).

By holding that the test for complete preemption was not met in these cases, the Fifth Circuit implicitly but correctly concluded that whatever sorts of complete preemption might otherwise be found within § 502(a), a properly pleaded Texas Act claim is not among them. Fundamental principles of federalism yield this result, given the importance of the "federalist structure of joint sovereigns" and the "proper balance between the States and the Federal Government." *Gregory*, 501 U.S. at 458, 459.

And whether the federal statute provides "any substitute for the traditional state court procedure for collecting damages for injuries caused by tortious conduct"—as ERISA manifestly does not—is particularly significant. *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656, 663-64 (1954) (in absence of any such substitute, the Court refused to "cut off the injured respondent from this right of recovery," noting that doing so would "deprive it of its property without recourse or compensation" and "in effect, grant petitioners immunity from liability for their tortious conduct"); *see also Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984) (in the absence of any "indication that Congress even seriously considered precluding the use of [tort] remedies," the Court declined "to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct"). Without any such substitute, plaintiffs who can establish that their injuries resulted from defendants' wrongful conduct under state law would be left wholly without a remedy, a result that should not readily be attributed to Congress. *See Ingalls Shipbuilding, Inc. v. Director, Office of Workers' Comp. Programs*, 519 U.S. 248, 261 (1997) (interpretations that are "absurd or glaringly unjust" must be avoided); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 486 (1996) (plurality opinion) (calling "implausible" any argument that Congress "effectively precluded state courts from affording state consumers any protection from injuries resulting from a defective medical device."). *Cf. Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 223 (2002) (Stevens, J., dissenting) ("Congress, of course, has the power to enact unreasonable laws. Nevertheless, instead of blind obedience to what at first blush appears to be such a law, I think it both prudent and respectful to pause to ask why Congress would do so.").

The Texas Act applies equally to all insurers and managed-care entities, including HMOs, without any reference to or connection with an ERISA plan. *See Corporate Health I*, 215 F.3d at 535 ("[t]he provisions are indifferent to whether the health care plan operates under ERISA and do not rely on the

existence of ERISA plans for their operation."). And the dissent in *Rush Prudential* acknowledged that "were a State to require that insurance companies provide all 'medically necessary care' . . . I have little doubt that such *substantive* requirements would withstand ERISA's pre-emptive force." *Rush Prudential*, 536 U.S. at 399 (Thomas, J., dissenting). The Texas Act does nothing more than establish a state substantive standard for HMOs making medical decisions, and when the clarity of this expression of traditional state regulation of health-care matters is contrasted with ERISA's silence, state law must win out.

B. The well-pleaded complaint rule and removal; under *Franchise Tax Board*, there is no removal jurisdiction when only a state-court defense of ERISA preemption might exist.

The HMOs' argument for judicially implied removability of state-law HMO medical-malpractice claims ignores the well-pleaded-complaint rule. More seriously, Petitioners' argument disregards the very narrow bases on which the Court has previously implied complete preemption to permit removal in derogation of that rule—bases that have at their foundation some degree of meaningful remedial overlap between state law and the federal statute said to displace that claim. Here, the Court should apply the well-pleaded-complaint rule and conclude that Calad and Davila have properly raised a state claim that is subject, at most, to a federal defense of § 514(a) preemption—a defense that Texas state courts are well-equipped to apply if appropriate. *See Franchise Tax Bd.*, 463 U.S. at 14 (case may not be removed on the basis of federal defense, including defense of ERISA preemption). That is, the existence of a federal *defense* to a state-law action is insufficient to render that action one "arising under" federal law within the meaning of 28 U.S.C. § 1331; a defendant wishing to assert such a defense must do so in state court.

The well-pleaded-complaint rule of course allows a plaintiff to control whether he or she wishes explicitly to assert some federal claim (assuming *arguendo* that Calad and Davila had a federal claim to assert at the time of filing, which they did not). *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 392 (1987) (federal jurisdiction exists only when federal question is presented on the face of properly pleaded complaint; plaintiff "may avoid federal jurisdiction by exclusive reliance on state law"); *Merrell Dow Pharms., Inc. v. Thompson*, 478 U.S. 804, 809 n.6 (1986) ("[j]urisdiction may not be sustained on a theory that the plaintiff has not advanced").[6]

The Fifth Circuit's holding that only a claim duplicating an existing one under ERISA is properly preempted and thus removable under § 502(a) finds support in *Rush Prudential*. There, the Court accurately noted that since *Pilot Life*, it had found only one other state law (the one involved in *Ingersoll-Rand*) to "conflict" with § 502(a) "in providing a prohibited alternative remedy." 536 U.S. at 379. As the Court explained *Ingersoll-Rand*, the state law did not just "*duplicate*[] *the elements of a claim* available under ERISA [a § 510 claim], it converted the remedy from an equitable one under [§ 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." *Id.* (emphasis added). *See also Franchise Tax Bd.*, 463 U.S. at 26-27 (before finding ERISA complete preemption for removal purposes, state claim must involve a "central concern" of ERISA, and ERISA must create "a federal cause of action to replace [the] preempted state . . . claim").

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6. *See also Franchise Tax Bd.*, 463 U.S. at 10, 12-14 (1983); *Gully v. First Nat'l Bank*, 299 U.S. 109, 116 (1936) ("[b]y unimpeachable authority, a suit brought upon a state statute does not arise under an act of Congress or the Constitution of the United States because prohibited thereby."); *Anderson*, 123 S. Ct. at 2065-70 (Scalia, J., dissenting) (discussing well-pleaded-complaint rule and criticizing cases finding complete preemption in derogation of that rule).

No case from this Court has held, in the § 502(a)(1)(B) context, that a state-law claim rooted in a duty other than that to properly pay a claim for ERISA benefits falls "within the scope" of § 502(a). *See Taylor*, 481 U.S. at 64.[7] Removal based on *Taylor* is limited to cases in which the complaint's allegations in fact state a claim under § 502, even though not actually citing § 502. *See id.* at 61, 66 (without mentioning § 502, complaint sought "reimplementation of all benefits" plaintiff was entitled to, and asserted only claim under state contract law; but factual allegations clearly stated a claim "within the scope . . . of § 502(a).").

Too, whether a complaint states a claim over which there is federal subject-matter jurisdiction turns on the facts as they exist when suit is filed, not on hypothetical facts or fleeting circumstances no longer applicable. Aetna and CIGNA object that Respondents would have had a § 502 claim *if* they had paid for the disputed care out of their own pockets and then sued for a refund. But whether a complaint states a federal claim depends on the actual facts, not on circumstances that might have come to pass if one or more of the parties had acted differently. *Franchise Tax Board* and *Taylor* permit a court, at most, to recharacterize the complaint actually filed, not to recharacterize an academically possible one that assumes different factual circumstances.

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7. The *Taylor* Court derived complete preemption not from § 502(a)'s text, but rather from language in the Conference Report that referred to "suits to enforce benefit rights under the plan or to recover benefits under the plan" as being considered to "aris[e] under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." 481 U.S. at 65-66 (quoting H.R. Conf. Rep. No. 93-1280, at 327 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5037, 5107). Whatever Calad's and Davila's claims are, they are neither of the types spoken of in the Conference Report.

C. Rarity of, and limitations on, judicially implied complete preemption.

Applying complete preemption presupposes that federal law specifically addresses the claim asserted in state court in a substantive manner and provides the exclusive remedial scheme (as, for example, in *Anderson*, *Taylor*, and *Avco Corp. v. International Ass'n of Machinists*, 390 U.S. 557 (1968)). But here, nothing could be further from the truth.

1. In rare cases, the well-pleaded-complaint rule is disregarded if a cause of action is one "arising under" a federal law whose "preemptive force . . . is so powerful as to displace entirely any state causes of action," *Franchise Tax Bd.*, 463 U.S. at 23, thus triggering judicially implied complete preemption and removal. *See Anderson*, 123 S. Ct. 2058 (finding state usury claim completely preempted where federal usury law provides both exclusive duplicate cause of action and exclusive remedy); *Taylor*, 481 U.S. 58 (relying heavily on *Avco* to completely preempt state claim seeking reinstatement of disability benefits and related relief, where § 502(a)(1)(B)'s enforcement scheme supplied the exclusive remedy for identical claim)[8]; *Avco*, 390 U.S. 557 (judicially

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8. Justice Scalia has questioned whether members of Congress even read their own committee reports. *Wisconsin Pub. Intervenor v. Mortier*, 501 U.S. 597, 620 (1991) (Scalia, J., dissenting) ("It is most unlikely that many Members of either Chamber read the pertinent portions of the Committee Reports before voting on the bill—assuming (we cannot be sure) that the Reports were available before the vote."). In light of this common-sense observation, one cannot reasonably assume that members of Congress are students of this Court's decisions. Whether Congress was actually aware of *Avco*'s interpretation of LMRA § 301 certainly cannot be gleaned from ERISA's text or its legislative history; the case is not mentioned. And because the LMRA, unlike ERISA, contains no express-preemption clause, it is at least as likely that Congress may have seen the struggles that courts had with § 301 before and up through *Avco*, thought *Avco* went too far, and decided to include an express-

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implying complete preemption of state-court action to enforce no-strike clause in collective-bargaining agreement, where case fell within scope of LMRA § 301, governing claims for violation of contracts between employers and labor organizations). *Cf. Anderson*, 123 S. Ct. at 2066 (Scalia, J., dissenting) (referring to *Avco* and its progeny as a "radical departure from the well-pleaded-complaint rule").

Despite the narrow confines of this Court's complete-preemption cases, discussed in greater detail below, what the HMOs are asking the Court to do is far wider in scope: for removal purposes, to judicially imply complete preemption of a statutory medical-malpractice claim that finds no substantive counterpart or remedy under ERISA even though, as shown by the scant attention the HMOs pay to the Court's restrictive view of § 514(a) "relates to" preemption, a serious question exists whether Texas Act claims relate to an ERISA plan in the first place. *See* Part II, *infra*.

In the instant cases, as in *Gully v. First Nat'l Bank*, 299 U.S. 109, 117 (1936), "[t]he most that one can say is that a question of federal law is lurking in the background, just as farther in the background there lurks a question of constitutional law, the question of state power in our federal form of government." But as the Court there noted, "[a] dispute so doubtful and conjectural, so far removed from plain necessity, is unavailing to extinguish the jurisdiction of the states." *Id.* Rather, "a right or immunity created by the Constitution or laws of the United States *must be an element, and an essential one*, of the plaintiff's cause of action." *Id.* at 112 (emphasis added). The Fifth Circuit pointed out the outcome-determinative, substantive differences between

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preemption clause and saving clause so that courts construing ERISA would not imply complete preemption that Congress did not intend. Such concededly "psychoanalytical" speculation, *see United States v. Public Utils. Comm'n of Cal.*, 345 U.S. 295, 319 (1953) (Jackson, J., concurring), would account for ERISA § 514.

a § 502(a)(1)(B) claim and those involved here: "Calad's and Davila's claims of *HMO medical malpractice* differ fundamentally from the § 502(a)(1)(B) claims we have recognized. . . . Calad and Davila assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan." Aetna Pet. App. 16a (emphasis added). Because "Calad and Davila advance only state law causes of action," the Fifth Circuit observed, "a straightforward application of the well-pleaded complaint rule would deprive the federal courts of original and removal jurisdiction over their claims." Aetna Pet. App. 8a.

Avco, the foundational case for the Court's § 502 complete-preemption holdings, does not undermine the Fifth Circuit's holding. There, the company sought injunctive relief in state court for the union's work stoppages done in violation of the parties' contract, even though the company could have asserted a federal claim under LMRA § 301. Despite the unavailability of injunctive relief in federal court, the Court held that the claims arose under § 301, which Congress fashioned to "place sanctions behind agreements to arbitrate grievance disputes." *Avco*, 390 U.S. at 559. Because the suit "arose under" § 301, removal was thus proper. *Avco*'s "necessary ground of decision was that the preemptive force of § 301 is so powerful as to displace entirely any state cause of action for violation of contracts between an employer and a labor organization." *Franchise Tax Bd.*, 463 U.S. at 23 (internal quotation marks omitted). Thus, a federal claim for breach of a labor contract displaces a state claim for breach of the same contract.

Within the quite-limited context of LMRA § 301 complete preemption, and the consequent quite-limited context of ERISA § 502(a) complete preemption—restricted, at least in both *Pilot Life* and *Taylor*, to claims for financial benefits—the Court's reasoning effectuates congressional intent that § 502(a) remedies not be "supplemented or supplanted." *Pilot Life*, 481 U.S. at 56. But that is not the case here. *See* Part I.D., *infra*.

2. The Court has often declined to find the requisite nexus between an otherwise-overpowering federal statute and a state-law claim, evidencing significant limits on judicially implied complete preemption. For example, in *Caterpillar, Inc. v. Williams*, 482 U.S. 386 (1987)—decided during the same term as *Pilot Life* and *Taylor*—a unanimous Court held that state-law claims for breach of individual employment contracts were not completely preempted by LMRA § 301 even though the plaintiffs were bargaining-unit members and could have sued for breach of the collective-bargaining agreement. "[A]s masters of the complaint, however, they chose not to do so." *Id.* at 395.

Furthermore, just as with Respondents' Texas Act claims, the plaintiff's complaint in *Caterpillar* was "not substantially dependent upon interpretation of the collective-bargaining agreement. It does not rely upon the collective agreement indirectly, nor does it address the relationship between the individual contracts and the collective agreement." *Id.* Moreover, the Court noted, "it would be inconsistent with congressional intent under [§ 301] to pre-empt state rules that *proscribe conduct, or establish rights and obligations, independent of a labor contract.*" 482 U.S. at 395 (citation omitted) (emphasis added). Because Texas has "proscribed conduct" and "established rights and obligations" that are independent of an ERISA plan, *Caterpillar*'s reasoning similarly forecloses the HMOs' argument for judicially implied complete preemption in these cases.

The Court made as much clear in *Franchise Tax Board*, noting that "even under § 301 we have never intimated that any action *merely relating* to a contract within the coverage of § 301 arises exclusively under that section." 463 U.S. at 25 n.28 (emphasis added). As an example, the Court commented that "a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract." *Id.* That passage can be paraphrased to fit here: "A state

medical-malpractice suit growing out of an HMO's violation of its duty to exercise professional ordinary care in making medical-necessity decisions would not arise under § 502(a) simply because that care may have been provided under employer-sponsored HMO membership." This Court's approach to LMRA § 301 demonstrates that the mere presence of a collective-bargaining agreement somewhere in the mix of facts (just as with the mere presence of an ERISA plan somewhere in the vicinity of an HMO's medical-necessity decision) does not transmute a state claim into one arising under federal law.

Because the Court placed great weight on comments in ERISA's legislative history concerning LMRA § 301, *see Taylor*, 481 U.S. at 65-66, the Court's view of § 301's limited preemptive scope applies equally here. And that scope is plainly delineated: state-law rights that exist independent of a contract governed exclusively by federal law are not preempted. *See also Norris*, 512 U.S. at 258, 260-61 (state wrongful-discharge tort claims not completely preempted; state law, not CBA, was "only source" of right not to be discharged wrongfully); *Livadas v. Bradshaw*, 512 U.S. 107, 123 (1994) ("§ 301 cannot be read broadly to pre-empt nonnegotiable rights conferred on individual employees as a matter of state law."); *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 (1988) (§ 301 does not affect substantive rights a state may provide to workers "when adjudication of those rights does not depend upon the interpretation of such agreements."). But despite this clear-cut reading of LMRA § 301 since *Pilot Life*, many ERISA defendants (such as Petitioners here) argue for a much broader interpretation of § 502(a)(1)(B) preemption than even LMRA § 301 preemption has ever enjoyed.

D. *Pilot Life* and *Taylor* do not provide a workable rule to extend to these cases.

1. Because preemption of claims for an ongoing withholding of financial benefits is not relevant when the claim is one for defective medical care, yet another reason exists not to expand complete preemption to the instant cases. In every ERISA complete-preemption case that has come before the Court to date, the "benefit" dispute involved a claim that a participant's entitlement to financial benefits was and continued to be denied on an ongoing basis. *Cf. Pilot Life*, 481 U.S. at 53 (under § 502, "[r]elief may take the form of accrued benefits due"). Section 502(a)(1)(B) may be well suited to resolve such a claim, as in *Pilot Life* and *Taylor*, but it raises a "puzzling issue of preemption," *Pegram*, 530 U.S. at 236, when the issue is one of state medical-malpractice law. That is, when an HMO member acquiesces in the HMO's dictate concerning a medical-necessity decision and then suffers harm, no ongoing denial of financial benefits is implicated; rather, both the claim (the duty) and its remedy are grounded solely in state law. Respondents do not ask the Court to overrule *Pilot Life*, only to hold that *Pilot Life* and *Taylor* should not be extended beyond their circumscribed boundaries.

In many malpractice actions arising out of medical misjudgments in a utilization review, moreover, the patient will never even submit a claim. In Calad's case, for example, she left the hospital when a CIGNA discharge nurse told her that she must. There never was a "benefits" claim for payment to process. Frequently the inexorable result of the utilization review system, and indeed its very purpose, is that no such claims will be submitted or pursued.

2. Although ERISA itself does not define "benefits," the most sensible view is that the ERISA benefit is simply the HMO membership. Such a construction allows the Court to recognize that medical-malpractice claims arising out of an HMO's defective medical-necessity decision involve only

state medical standards and state-law remedies. This approach makes particular sense when one bears in mind that the HMO is an entity distinct from the ERISA plan. *Rush Prudential*, 536 U.S. at 359 (HMO "contracts to provide medical services" for ERISA plans); *Pegram*, 530 U.S. at 223, 227 ("[t]he HMO is not the ERISA plan"); *Travelers*, 514 U.S. at 659 (noting that ERISA plans *buy* health insurance).

In fact, at least one HMO, one jurist, and one commentator have all contended that the ERISA "benefit" should be read as limited to HMO membership; it was the precise position taken *by the HMO* in *Pegram*: "The sole benefit in the plan 'established or maintained by [the] employer' here is membership in the CarleCare HMO"; the HMO was not "'established' and is not 'maintained' by the 'employer,'" thus the HMO's "internal decisions about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA 'employee welfare plan.'" Pet'r. Br. at 24-25, *Pegram*, 530 U.S. 211 (2000) (No. 98-1949). Because HMO membership "is the sole benefit" under the employer's plan, the HMO's "discretionary decisions about the provision of health care for a member . . . do not constitute 'administ[ration]' or 'manage[ment]' of an 'employee welfare plan'. . . ." *Id.* at 25.

In dissenting from the denial of rehearing *en banc* in *Pegram*, Judge Easterbrook made the same point: "[I]f . . . one conceives of the CarleCare HMO system *as the benefit promised by the* ERISA *plan*, then Carle is not a 'fiduciary.' It is just the supplier of medical care. . . ." Preserving the sponsors' and participants' freedom of choice "means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan." 170 F.3d 683, 686 (7th Cir. 1999) (Easterbrook, J., dissenting). *See also* Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Hous. L. Rev. 985, 1050 (Winter

1998) ("Jacobson") ("the [HMO] clinical decision making that results in the provision of care . . . is not a function constituting the [ERISA] plan, but is a service to the plan. . . . Consequently, the benefit would be the membership in the [HMO], not the particular medical care solicited or provided."). This reading is entirely consistent with CIGNA's management of a provider network, and with Aetna's Group Agreement and Certificate of Coverage, the latter of which plainly speak in terms of eligibility to enroll in *the HMO*, not in the ERISA plan. J.A. 27-28, 33-34, 48.

3. Even if the ERISA benefit is seen as more than the HMO membership, *Pilot Life* controls only in appropriate situations—but determining the proper context of those situations is crucial. In *Pegram*, the Court held that HMOs making determinations with both a medical-treatment and an eligibility aspect are not ERISA fiduciaries, a holding that hints at the numerous problems inherent in federalizing medical-malpractice law. *Pegram*, 530 U.S. at 231. Because allowing the *Pegram* plaintiff's claims for breach of ERISA fiduciary duty would be tantamount to recognizing federal preemption of state regulation of HMO medical decisions, the Court declined to hold that an HMO member could sue, under ERISA's fiduciary provisions, for an HMO's mixed decisions. Because "[t]he HMO is not the ERISA plan," *id.* at 227, removal jurisdiction can inhere only if an HMO is functioning as a pure ERISA fiduciary—something it is not doing when making a mixed decision such as one involving medical necessity—and thus subject to § 502(a)(1)(B)'s remedial scheme.

Pilot Life does not resolve, or even address, the present issue: what are the boundaries of the term "benefits" that appears in § 502(a)(1)(B), in the context of medical treatment when an HMO makes medical-necessity decisions in administering its own business? "Benefits" cannot logically be interpreted to include an externally mandated medical standard of ordinary care under state law, which Congress

somehow intended for ERISA to usurp without—unlike in the area of pension benefits—providing in its place any substantive rule.[9] Plainly, "ERISA has nothing to say," *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001), about medical standards of ordinary care, a topic left entirely to the states.[10]

Pegram, on the other hand, allows an HMO member to pursue a non-ERISA claim based on what the Court unanimously characterized as the "malpractice standard traditionally applied in [state-court] actions against physicians." 530 U.S. at 235. Consistent with notions of federalism and the states' traditional role in regulating health-care matters, because HMOs' medical-necessity decisions are not fiduciary in nature neither do they implicate section 502(a)'s remedies where a state-law malpractice action is involved, as the Fifth Circuit concluded: "Because the [Texas Act] does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*. . . . We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law

9. Petitioners argue that *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), "conclusively establishes that medical necessity determinations under an ERISA plan concern benefits administration, not medical treatment." Aetna Br. 35. Aside from the facts that the case involved an ongoing withholding of benefits and involved no state regulation, and that the plaintiff there filed a § 502(a)(1)(B) claim to recover financial benefits that he claimed were being wrongly denied him, *Nord* simply held that, unlike Social Security Administration regulations that require deference to a treating physician's opinion on disability, nothing in ERISA or its regulations suggest that a plan fiduciary (there, the employer) who retains absolute discretion over the ERISA plan must similarly defer to a treating physician. Moreover, disability plans do nothing to affect the medical care that a disabled person receives.

10. *See also Boggs v. Boggs*, 520 U.S. 833 (1997) (given *specific* ERISA provisions governing disposition of pension-plan benefits, ERISA preempts state community-property law that conflicts with those provisions).

under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B)." Aetna Pet. App. 20a.

4. The United States now suggests that in enacting ERISA, Congress intended to federalize medical-malpractice law as far as HMOs are concerned, and to create in place of state malpractice remedies a system for patients to rush to federal court for emergency relief. Brief of the United States 27 (citing *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992), in which a temporary restraining order issued in 24 hours). The United States advocates that every patient who fears injury because of an HMO's medical decision should bring, in federal court, an emergency injunction action under § 502(a). But the idea that patients in Calad's position would have the wherewithal (financial and otherwise) to find a lawyer and pursue injunctive relief while lying in a hospital bed recovering from major surgery and general anesthesia is unrealistic, to say the least. And one can only imagine the puzzlement that an immediate injunction action to force Aetna to approve Vioxx would have engendered when a court learned Davila was taking the generic drug Aetna insisted he have, presumably with some pain relief (though it would turn out to almost kill him a few weeks later).

A far more basic problem exists with the sue-for-an-injunction approach, beyond the fact that it is a theoretical one for purposes of the claims Calad and Davila did file in 2000. Federal judges would be hard pressed to deny such emergency requests for medical care, since the potential physical injury would usually be irreparable, and the patients would have no other remedy; federal judges who lack state-court expertise in medical-malpractice litigation would be required to resolve in a matter of days (or hours) issues that state courts normally determine at a far more deliberative pace. The idea that Congress meant to supersede traditional state malpractice claims by promoting tens of thousands of federal temporary-injunction actions involving medical-

necessity determinations is inconceivable. And it is belied by the United States' position in other cases and the Department of Labor's regulatory comments. *See* Part II.B., *infra*.

II. Section 502 complete preemption presupposes § 514(a) "relates to" preemption; but § 514(a)—ERISA's only express preemption provision—does not preempt claims under the Texas Act for defective HMO medical-necessity decisions.

In each of its § 502(a) cases, the Court first determined whether the state law at issue "related to" an ERISA plan within the meaning of § 514(a). *E.g.*, *Rush Prudential*, 536 U.S. 355; *Ingersoll-Rand*, 498 U.S. 133; *Taylor*, 481 U.S. 58; *Pilot Life*, 481 U.S. 41.[11] Congress specifically addressed the issue of preemption in § 514(a), and mandated preemption only of state laws that so "relate." Controlling importance should ordinarily be given to Congress's decision to restrict preemption to state laws that relate to an ERISA plan. Where a state law falls outside the scope of § 514(a) preemption, an inference of implied § 502(a) complete preemption should be drawn, if at all, only on the most compelling showing.[12] But going straight to a § 502(a) analysis before determining whether a state claim even "relates to" an ERISA plan ignores

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11. In *Pilot Life*, the Court did not reach the § 502 issue until after first determining both that § 514(a) applied, and that the common-law claim of bad faith was not saved from conflict preemption as a law that regulates the business of insurance. 481 U.S. at 47-51. Moreover, the Court discussed § 502 in the context of interpreting § 514 rather than as a stand-alone reason to find that suits such as Dedeaux's should be "treated as federal questions governed by § 502(a)." *Id.* at 51-52, 56.

12. Although theoretically a situation might exist in which § 502 complete preemption could be implied even without § 514(a) express preemption, these cases do not present such a situation. Respondents' medical-malpractice claims neither relate to an ERISA plan nor fall within the scope of § 502(a)(1)(B); the Court's ruling in these cases need be no broader than that.

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the analytical pattern of this Court's § 502(a) precedents–and presupposes a crucial fact that might or might not be true. Here it is not.

Before expanding § 502(a) judicially implied complete preemption to these two cases, the Court should thus consider what Congress explicitly said about preemption in § 514(a), and about the exceptions it carved out from that preemption. Neither the language of § 514(a) nor the policy behind ERISA shows that Congress intended to preempt a state statute giving patients the right of redress against an HMO for its flawed treatment-related decisions, where that medical-malpractice statute functions regardless of whether patients obtain HMO membership through an ERISA plan or otherwise. *See BFP*, 511 U.S. at 546 ("where the intent to override [historical state practice] is doubtful, our federal system demands deference to long-established traditions of state regulation"); *Gregory*, 501 U.S. at 464 ("[t]o give the state-displacing weight of federal law to mere congressional *ambiguity* would evade the very procedure for lawmaking on which *Garcia* [*v. San Antonio Metro. Transit Authority*, 469 U.S. 528 (1985)] relied to protect states' interests") (internal quotation marks, citation omitted).[13]

13. Because Calad's co-plaintiff, Walter Thorn, was a member of a "governmental plan" to which ERISA's preemption provisions expressly do not apply (29 U.S.C. §§ 1003(b)(1), 1144), his Texas Act claims against the same Aetna HMO involved in Davila's case have gone forward in state court. Should the Court agree with Petitioners here, identical medical-necessity decisions will be preempted (or not) depending entirely on the coincidence of who happens to pay the HMO dues or premiums. At a minimum, this should lead the Court to consider whether the actual ERISA "benefit" is the payment of HMO dues or premiums.

A. *Pegram*'s unequivocal statement that HMO "mixed" decisions are not preempted.

In *Pegram*, the plaintiff complained that her health-care provider, a group of doctors who could earn bonuses through their physician-owned HMO by minimizing care and referring patients only to facilities controlled by the group, breached an ERISA fiduciary duty. The Court disagreed. Notably, the Court did not limit its reasoning only to doctor-owned HMOs: "courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs." 530 U.S. at 222.[14] According to *Pegram*, "federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim." *Id.* at 236. But "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 237 (citing *Travelers*).

Importantly, this Court recognized in *Pegram* that HMO health-care-treatment decisions involve both administrative (eligibility) decisions and pure treatment decisions involving "the appropriate medical response" (the subject, most plainly, of state malpractice laws). *Id.* at 227-28.[15] The Court observed that these decisions "are often practically inextricable from one another," something that is so "*not*

14. Additionally, the Court noted without disapproval that the plaintiff's original malpractice claim against her HMO doctor was tried to a favorable jury verdict, *Pegram*, 530 U.S. at 217, and further noted that states vary regarding whether to "allow malpractice actions against HMOs," *id.* at 235, at the very least implying that ERISA does not bar state-law tort suits against HMOs.

15. *Pegram* defined "treatment decisions" as "choices about how to go about diagnosing and treating a patient's condition. . . ." 530 U.S. at 228. This is strikingly similar to the Texas Act's definition of a health-care-treatment decision, *see* § 88.001(5), and to what CIGNA and Aetna did here.

merely because, under a scheme like Carle's, treatment and eligibility decisions are made by the same person, the treating physician," but rather because "a great many and possibly most coverage questions are not simple yes-or-not questions"; the "more common coverage question is a when-and-how question." *Id.* at 228 (emphasis added).

Pegram's holding was premised on a recognition that ERISA does not preempt malpractice claims against an HMO whose physicians provided the assertedly inadequate care, even where the treatment decision involved a mixed treatment and eligibility determination. An HMO or other entity should not be permitted to avoid malpractice liability simply because it organizes its affairs so that—as in the instant cases—the same mixed decision is made by a physician or nurse or pharmacist who does not happen to be the patient's own treating physician.

The Court concluded that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231.[16] A finding of no fiduciary status with regard to mixed decisions (a category that subsumes medical-necessity decisions) is tantamount to a broader finding that ERISA does not preempt other types of claims, because if an HMO's mixed decisions are not fiduciary in nature, neither

16. The Court's "acting through its physicians" phrase does not alter the analysis, for there is no fundamental difference (certainly not in the ultimate effect) between an HMO that employs medical judgment in determining "medical necessity" and one that does so through employee physicians' (or their subordinates') own judgments. *See also supra* n.14; *Pegram*, 530 U.S. at 222 ("We think, then, that courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs.").

can they give rise to any other sort of ERISA claim.[17] *See, e.g.*, ERISA § 502(d)(2), 29 U.S.C. § 1132(d)(2) (authorizing monetary relief only against ERISA plans and fiduciaries).[18] CIGNA admits as much in its brief, noting that

17. *See also* Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest after* Pegram v. Herdrich, 36 Tort & Ins. L.J. 687, 718 (Spring 2001) ("Stempel") (Based on *Pegram*, if HMO is "essentially a vendor providing supervised medical services," ERISA should not preempt claims "merely because this vendor attempts to manage its delivery of services" in such a way as to lower costs and increase profits "in connection with its contract with an ERISA plan.").

> [A]ccording to *Pegram*, HMOs are almost never fiduciaries under an ERISA plan and are almost never subject to fiduciary liability under ERISA. Logically, these same HMOs can almost never be pure plan administrators subject to ERISA preemption and immunity. Hence, actions against them will almost never affect the ERISA plan in a way that warrants preemption. Rather, state law claims against the HMO relate to the HMO and its performance.

Id. at 722. *See also Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, 72 U.S.L.W. 3093 (U.S. July 11, 2003) (No. 03-69).

18. CIGNA equivocates about whether it was functioning as some sort of ERISA fiduciary (*e.g.*, CIGNA Br. 35-39)—the only way in which it can try to gain ERISA's protections against liability for its medical malpractice. Aetna, on the other hand, claims that it "makes no difference whether or not Aetna was acting in a fiduciary capacity" (Aetna Br. 32 n.15), presumably because the Group Agreement between it and Davila's employer conclusively establishes just the opposite. J.A. 31. But in fact the HMOs' status *does* make a difference. If an HMO is not a fiduciary, ERISA affords no means to recover a money judgment against it; even if it is nonetheless a fiduciary in some limited administrative sense, the HMO then runs into *Pegram*'s holding that "mixed" decisions take it outside that realm for purposes of a state malpractice claim.

a state malpractice claim, even when "mixed" with a "benefit determination" would "not require the plaintiff to prove a breach of the terms of the ERISA plan, only that the treatment itself was improper." CIGNA Br. 33 n.5.

B. The Department of Labor's agreement, both before and after *Pegram*, that ERISA does not preempt an HMO's mixed decisions.

The position now taken by the United States is inconsistent with interpretations of ERISA previously advanced by the Department of Labor. The Department adopted Respondents' reading of *Pegram* in *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pennsylvania Hosp. Ins. Co.*, 536 U.S. 938 (2002). *See* Secretary of Labor Br., 2000 WL 34016555 (Sept. 22, 2000). The Department read *Pegram* as establishing that § 514 "does not preempt state law that applies to the HMO's medical treatment decisions, even when they are what the Court described as 'mixed' treatment and eligibility decisions," *id.* at *9, and that mixed decisions "are governed by state malpractice standards and not by ERISA fiduciary standards," *id.* at *11. Following *Pegram*'s approach, then, the Department of Labor concluded that the Pennsylvania Supreme Court "should hold that [the HMO] may have made a 'mixed' treatment and eligibility decision and, *if it did, ERISA does not preempt a state negligence action challenging the decision*." *Id.* at *11-12 (emphasis added).

Explaining further, the Department found "no . . . manifestation of preemptive intent with respect to the general category of treatment decisions that are intertwined with eligibility determinations by an HMO, i.e., coverage decisions that involve or implicate medical judgments. . . ." *Id.* at *12. Because "ERISA's overriding purpose is to protect the interests of participants and beneficiaries" by "round[ing] out the protection afforded participants by eliminating the

threat of conflicting and inconsistent State and local regulation," *id.* at *12-13, preemption would undermine those goals "if an HMO can escape responsibility as an ERISA fiduciary for its 'mixed eligibility decisions,' as *Pegram* holds, and also avoid state malpractice law," *id.* at *13.

Even before *Pegram*, the Department of Labor advanced this view in its *amicus* brief to the Fifth Circuit in *Corporate Health I*. Br. of Secretary of Labor, *Corporate Health I* (Nos. 98-20940 & 98-20981) (Mar. 12, 1999). There, the Department correctly recognized that the Texas Act liability provisions in their entirety do not "relate to" ERISA plans, because when a managed-care entity acts as an arranger and provider of medical treatment, "it is operating in a traditional sphere of state regulation, the provision of health care, which the Supreme Court has said is not preempted absent a clear expression of Congressional intent." *Id.* at 7 (citing *Travelers*). As early as 1998, the Department of Labor had filed *amicus* briefs in eight other cases, arguing every time that "ERISA does not preempt negligence or medical malpractice claims against HMOs when the plan participant is part of an employer-based health plan." United States General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* 20 and n.38 (July 1998) (GAO/HEHS-98-154) (collecting cases).

The 2002 Department of Labor regulations to which Petitioners refer, 29 C.F.R. § 2560-503-1 (setting out claim and review procedures applicable to employee benefit plans, including group health plans), do not impose any substantive regulation of the *quality* of a particular medical-necessity decision, something (again) left entirely to state law.[19]

19. As CIGNA makes clear, 29 C.F.R. § 2560.503-1 was not promulgated until *after* the events in both Calad's and Davila's cases had occurred. CIGNA Br. 44. Furthermore, the Department of Labor regulations contain the same exception to preemption found in ERISA § 514(b)(2)(A) for state insurance regulation. 29 C.F.R. § 2560.503-1(k).

In commentary accompanying its proposed new regulations, the Department noted that those regulations "did not address section 514 . . . *or in any way propose to regulate* the relationship between the proposed minimum standards for benefit claims procedures of employee benefit plans and *State law that might affect or relate to such standards*." 65 Fed. Reg. 70246, 70254 (Nov. 21, 2000) (emphasis added).

More notably, the Department took the same position concerning *Pegram* that the Fifth Circuit did below: "Nothing in this regulation should be construed to limit a claimant's ability to pursue any state law remedy that may be available *as a result of a medical decision, even where such decision implicates eligibility for benefits under a plan. See Pegram* [full citation omitted]." 65 Fed. Reg. 70246, 70254 n.34 (emphasis added). The Department of Labor thus recognized that the classic situation for implying preemption—an impossible conflict with federal law, or frustration of congressional purpose, *e.g.*, *Geier v. American Honda Motor Co.*, 529 U.S. 861 (2000)—simply does not exist. *See also Hillsborough County*, 471 U.S. at 714 (preemption argument faced "uphill battle" (and lost) where federal agency stated that its regulations were not meant to be exclusive, and were not intended to usurp state powers).

C. The plain text of § 514(a): "supersede"; the absence of anything in ERISA or its regulations to supersede state laws regulating the substantive quality of medical decisions.

ERISA "supersede[s] any and all State laws" that "relate to" an employee-benefit plan. 29 U.S.C. § 1144(a). The Court has construed the word "supersede" to ordinarily mean "'to displace (and thus render ineffective) *while providing a substitute rule*.'" *Humana, Inc. v. Forsyth*, 525 U.S. 299, 307 (1999) (quoting Br. for United States as *Amicus Curiae* 17, n.6) (emphasis added); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 136 (1992) (Stevens, J., dissenting) (emphasizing that ERISA uses the

word "supersede"—meaning to replace, not to nullify—rather than "preempt," and concluding that "if we were to decide this case on the basis of nothing more than the text of the statute itself, we would find no pre-emption (more precisely, no 'supersession') of the District's regulation of health benefits . . . because that subject is entirely unregulated by ERISA"); Jacobson, 35 Hous. L. Rev. at 1003 (pointing out difference between "supersede" and "preempt," and noting that plain-language interpretation "would demand that ERISA only supersede state laws that regulate an area of employee benefit plans already covered by ERISA.").

A "substitute rule" dealing with the situation at hand, where an HMO member has been harmed by a defective HMO medical-necessity treatment decision, is nowhere to be found in ERISA, or in any Department of Labor regulation. *See also Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 16 (1987) ("It would make no sense for pre-emption [of state severance-pay law] to clear the way for exclusive federal regulation, for there would be nothing to regulate" because no administrative activities—ERISA's overriding regulatory concerns—were involved). To the contrary, if ERISA preempted state medical-malpractice claims, patients in need of relief for HMO medical malpractice are left in a statutory abyss. *See, e.g., DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 467 (3d Cir. 2003) (Becker, J., concurring) (finding it "unlikely that Congress intentionally created this so-called, 'regulatory vacuum,' in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute").[20]

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20. Although Petitioners describe at length what they consider "remedies" that Respondents could have pursued under a different set of facts (*e.g.*, filing an injunction action, or paying for care out of pocket and then seeking reimbursement), they neatly side-step what sort of "remedy" is available under ERISA when an HMO member does exactly what the HMO says and accepts its medical-necessity determination, but to great resulting harm. Of course, there is none.

D. The Court's tempering of a previously expansive view of "relates to" preemption; Congress did not intend to preempt state health-care quality standards.

This Court long ago commented that § 514 is "not a model of legislative drafting," *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), but construed it literally—at least initially—in the broadest possible terms, to apply if a state law had a "reference to" or even a "connection with" an ERISA plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). *See also Pilot Life*, 481 U.S. at 45-47; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Even under such a broad reading, the Court recognized that § 514 had its limits: "Congress pre-empted state laws relating to *plans*, rather than simply to *benefits*." *Fort Halifax*, 482 U.S. at 11.

Despite its early sweeping interpretation of "relates to" preemption, a unanimous Court later recognized the unworkable nature of casting the preemptive net too widely: "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Travelers*, 514 U.S. at 655 (internal punctuation, citation omitted). Instead, "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here." *Id.* With *Travelers*—which held not preempted a state law requiring hospitals to collect surcharges from patients insured by commercial carriers but not patients insured by a Blue Cross/Blue Shield plan—the Court put an end to an unnecessarily literal interpretation of § 514's "relates to" language.

The *Travelers* Court first dismissed the idea that the state law made "reference to" ERISA plans. As with the Texas Act, the state surcharge law was imposed "regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private

purchase, or otherwise. . . ." *Id.* at 656. In next turning to *Shaw*'s "connection with" test, the Court conceded that "here an uncritical literalism is no more help than in trying to construe 'relate to.' For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections." *Id.* Instead, courts "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive [preemption]." *Id. See also Boggs*, 520 U.S. at 841 (eschewing "relates to" analysis and instead simply asking whether state law "conflict[ed] with the provisions of ERISA or operate[d] to frustrate its objects.").

A surcharge law that had only an indirect economic effect on "choices made by insurance buyers, including ERISA plans," did not relate to an ERISA plan: such an influence "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . ." *Travelers*, 514 U.S. at 659. And there was more:

> [T]he existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely. *Quality standards*, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits.

Id. at 660 (emphasis added). Moreover, the *Travelers* Court observed that Medicare's history "confirm[ed] that Congress never envisioned ERISA pre-emption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation. . . ." *Id.* at 667 n.6. If the states were left free to "experiment" with health-care *cost* controls, surely Congress left them the same freedom when it came to health-

care *quality* standards, a far more venerable area of historic state police power.

At bottom, then, *Travelers* rested upon two notions: (1) state laws with "only a tenuous, remote, or peripheral connection with covered plans" were not preempted; and (2) "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661. The Texas Act claims raised here fall within both rationales.

Two years later, the Court noted that because ERISA did not modify the "starting presumption that Congress [did] not intend to supplant state law" falling within areas of traditional state regulation, a party raising preemption "bear[s] the considerable burden of overcoming" that presumption. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) (holding that even a direct tax on an ERISA plan does not require a finding of state-law preemption); *see also California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 330 (1997) (there must be an "indication in ERISA [or] its legislative history of [an] intent on the part of Congress to pre-empt" a "traditionally state-regulated *substantive* law.") (internal alterations, emphasis added).

The trilogy that comprises *Travelers*, *De Buono*, and *Dillingham* thus applied a common-sense interpretation to the seemingly infinite reach of § 514's "relates to" language. Of particular note is the following passage from *Dillingham*, a case (like *Travelers*) holding that simply because a state law has an economic impact on ERISA plans, that impact is too tenuous to justify preemption:

> Indeed, if ERISA were concerned with any state action—*such as medical-care quality standards* . . .—that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach . . .

Dillingham, 519 U.S. at 329 (emphasis added).[21]

The Court's retrenchment from the virtually limitless view of ERISA *conflict* preemption that inhered when it decided *Pilot Life* and *Taylor* is critical to a proper view of what kinds of disputes about "benefits" fall within the scope of § 502(a)(1)(B). The Court has now clearly distinguished between purely administrative decisions (such as eligibility), and the far more common ones involving both a coverage and a treatment decision, the examination of which under ERISA would require developing a body of federal malpractice—something the *Pegram* Court expressly disavowed. Even though the more circumspect approach to § 514 taken by this Court and by the Department of Labor (at least until recently) goes far toward reconciling congressional expressions of preemption with principles of federalism, a thorough examination of that section's effect on Respondents' claims would be incomplete, as *Pilot Life* teaches, without also considering § 514(a)'s legislative history.

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21. *See also Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring)

> [A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. [Citation omitted.] The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not. I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the 'relate to' clause . . . is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating 'employee benefit plan[s]'.

E. Section 514(a)'s legislative history, considered anew in light of the preceding year's Federal HMO Act and its legislative history.

In *Pegram*, for the first time in ERISA jurisprudence the Court made explicit the usefulness of also considering the Federal HMO Act of 1973, 42 U.S.C. § 300e, *et seq.*, passed during the same congressional term and just a year before ERISA; that Act's legislative history shows that Congress intended the states to regulate HMO medical quality—exactly as Texas has done here. This congressional intent is in harmony with ERISA's legislative history.

1. The enacted version of § 514(a) was drafted in conference, and the Court has (correctly) observed that there is little legislative history explaining how far it extends. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (characterizing the legislative history as "sparse"). The changes to § 514—made a mere ten days before final congressional action on ERISA—passed "without serious discussion of their significance." Rosenblatt at 174. The dissent in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), attempted to reconcile the early and final versions of § 514 as "an editorial amalgam of the two bills rather than as a major expansion of the section's coverage."[22] Applying the presumption against invalidating generally applicable state rules "leads me to the conclusion that the pre-emption clause should apply only to those state laws that

22. Early versions of § 514 discussed its preemptive effect as concerning either state laws "relat[ing] to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans" (H.R. 2, 93rd Cong., 1st Sess., § 114 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print), at 50-51 ("Leg. Hist.")), or state laws that "relate to the subject matters regulated by this Act" (S. 4, 93rd Cong., 1st Sess., § 609(a) (1973), *reprinted in* 1 Leg. Hist. at 186). The conference report did not explain why or how these specific preemption provisions from both chambers became transmuted in conference into the final language.

purport to regulate subjects regulated by ERISA or that *are inconsistent with ERISA's central purposes*." *Id.* at 67 (Stevens, J., dissenting) (emphasis added).

The House Committee on Education and Labor made clear that § 514(a)'s core purpose was to establish uniform federal standards regarding certain aspects of *pension* plans:

> Except where plans are not subject to this Act and in certain other enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law *in the areas of vesting, funding, insurance and portability standards, for evaluation of fiduciary conduct, and for creating a single reporting and disclosure system in lieu of burdensome multiple reports.*

House Comm. on Education and Labor, H.R. Rep. No. 93-533, at 17, *reprinted in* 2 Leg. Hist. at 2364 (emphasis added). *See also* Senate Comm. on Labor and Public Welfare, S. Rep. No. 93-127, at 35, *reprinted in* 1 Leg. Hist. at 621 (same). Neither the House nor the Senate Committee expressed concern with state laws beyond those that might affect the highlighted subjects. *Cf.* Jacobson, 35 Hous. L. Rev. at 998 ("In thousands and thousands of pages, welfare benefit plans are mentioned only a handful of times.")[23]

23. *See also* Donald T. Bogan, *Protecting Patients' Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 951, 972, 976-77 (Feb. 2000) ("Bogan") ("ERISA's legislative history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans"; "[t]here is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of non-pension benefit plans, or of any specific concern with the management of nonpension plan assets. . . .").

Senator Javits, one of ERISA's sponsors, extolled ERISA as "nothing less than a pension 'bill of rights,'" 3 Leg. Hist. at 4751, and discussed what § 514 was intended to accomplish: "State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans . . . establishing State termination insurance programs, et cetera, will be superseded." 3 Leg. Hist. at 4771. This statement is both consistent with ERISA's goals of protecting workers, *see* 29 U.S.C. § 1001, and indicative of the types of state regulation that Congress had in mind to preempt.

2. Further, the Federal HMO Act, 42 U.S.C. § 300e *et seq.*, enacted just a year before ERISA and during the same congressional term, shows that Congress intended the *states* to regulate HMO quality and never contemplated that HMOs would be able to commandeer the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a (putative) plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to immunize a process whereby HMOs decide what care is appropriate—that is, medically necessary—including such things as the "when-and-how question[s]" that arise when "physicians . . . decide what to do in particular cases." *Pegram*, 530 U.S. at 228-29. The role of state regulation of HMO medical decisions contemplated by the Federal HMO Act is inconsistent with a construction of ERISA that would immunize HMOs that violate state standards for treatment decisions.

Though Congress explored implementing comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance, it ultimately decided *not* to create such a commission, instead leaving quality-of-care

regulation to the states.[24] But even while such a Commission was being considered, the 1973 Senate Report reflected a "decision to encourage states to develop their own standards [regulating HMO conduct]" because "experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards." Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 93rd Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. at 3077, 87 Stat. 914.

At bottom, it makes no sense to suppose that just one year after adopting the federal HMO Act—and deliberately leaving HMO quality-of-care standards to the states—the same term of Congress intended through ERISA to usurp the states' ability to regulate the quality of medical care that HMOs provide, without a word so indicating. The legislative history of these two acts shows a Congress not only unconcerned with preempting state medical-quality regulation (through ERISA's total silence on this issue) but in fact, through the HMO Act, intent on preserving and encouraging state regulation and oversight in that very area.

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24. Much of the 1973 Senate Report dealt with the proposed commission, *see* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, but the actual HMO Act dropped it altogether when finally enacted. The Court has more than once considered Congress's rejection of a proposed statutory provision in construing an act's final language and the congressional intent behind it. *See, e.g., Crosby v. National Foreign Trade Council*, 530 U.S. 363, 378 n.13 (2000) (fact that "Congress repeatedly considered and rejected targeting a broader range of conduct lends additional support to our view"); *Blau v. Lehman*, 368 U.S. 403, 410-12 (1962) (inferring scope of potentially liable parties under federal insider-trading statute from Congress's early drafts).

III. Even if the Texas Act were otherwise conflict preempted under § 514(a), two express exceptions to preemption—the insurance saving clause and the federal-law exception—apply here.

The Texas Act is saved from any arguable preemption by virtue of two statutory exceptions in ERISA: the insurance saving clause and the federal-law exception. These exceptions reveal additional problems with relying on *Pilot Life* and *Taylor* in this context, inasmuch as both cases first found § 514(a) preemption *and* the inapplicability of the insurance saving clause before judicially implying § 502(a) complete preemption. Following the pattern of this Court's precedents, even if conflict preemption is found to exist the Court should also consider whether any exception to that preemption is present before reaching the § 502(a) issue. And that inquiry is made by looking at Congress's expressed intent, as determined from the plain text of what it said in enacting exceptions to ERISA preemption. Notably, the insurance saving clause provides that "nothing in this subchapter"—not merely "nothing in § 514"—shall preempt state insurance regulation; the plain language of § 514(b)(2)(a) thus applies to § 502 as well.

The instant cases were argued before *Rush Prudential* was handed down and thus before this Court held that state regulation of HMO medical-necessity decisions falls within ERISA's insurance saving clause. (The Fifth Circuit did briefly discuss *Rush Prudential*, though not on this point. Aetna Pet. App. 19a-20a.) Both Petitioners cite *Rush Prudential* extensively yet overlook its core holding: state regulation of HMO medical-necessity decisions is removed from § 514(a)'s preemptive scope by the insurance saving clause. In light of *Rush Prudential*'s issuance after briefing and argument below, Respondents discuss the insurance-exception here in the context of proposed § 502 complete

preemption.[25] A prevailing party may advance any ground supporting a judgment below in its favor so long as it would not modify the judgment. *Trans World Airlines, Inc. v. Thurston*, 469 U.S. 111, 119 n.14 (1985); *Dandridge v. Williams*, 397 U.S. 471, 475 n.6 (1970). And because Petitioners' Question Presented of § 502 preemption is one of judicial implication, the Court considers any express-preemption and saving-clause issues before implying preemption. *E.g.*, *Geier*, 529 U.S. 861; *International Paper Co. v. Ouellette*, 479 U.S. 481 (1987). The insurance saving clause's encompassing of Texas regulation of HMO medical-necessity decisions is "fairly included" in the Question Presented. Sup. Ct. R. 14.1(a).

A. *Rush Prudential*'s holding that state regulation of HMO medical-necessity decision-making falls within the insurance saving clause; Texas Act not preempted because saving clause preserves "any" and "all" state laws regulating the business of insurance.

ERISA § 514(b)(2)(A) provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." The Court has construed the saving clause as being phrased with similar breadth as § 514(a)'s conflict-preemption clause. *E.g.*, *Metropolitan Life*, 471 U.S. at 739-40, 746 ("while the

25. Respondents touched briefly upon the saving-clause issue in their briefing to the Fifth Circuit, noting that the Court had granted certiorari in *Rush Prudential* and that the insurance saving clause was involved. Calad 5th Cir. Br. 24 n.44; Davila 5th Cir. Br. 29 n.55. And in a post-argument letter brief that is part of the Fifth Circuit record, Respondents pointed out that *Rush Prudential* "held that Illinois' independent review provision . . . was not preempted by ERISA, given that the IRO provision was limited to 'medical necessity' determinations," and that cases brought to the appellate court's attention post-argument, including *Rush Prudential*, "affirm the right of the states to regulate HMOs when they practice medicine through so-called 'medical necessity' decisions. . . ."

general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation"; "[n]othing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause.").

And as with health-care matters, insurance has always been viewed as a special area of state regulation to be zealously protected from federal control. *See id.* at 744 n.21 ("Congress' 'primary concern' in enacting McCarran-Ferguson was to 'ensure the States' continued ability to regulate the business of insurance.'"). Moreover, as the U.S. Chamber of Commerce has observed—in its *amicus* brief supporting Petitioners—"[s]tate insurance law provides a *real safeguard against abuses by HMOs*. As this Court has established, HMOs are subject to state insurance laws." Chamber Br. 20 (emphasis added). *Cf. Rush Prudential*, 536 U.S. at 399 (Thomas, J., dissenting) ("were a State to require that insurance companies provide all 'medically necessary care' . . . I have little doubt that such *substantive* requirements would withstand ERISA's pre-emptive force."). Texas has taken a realistic approach to such insurance regulation by requiring HMOs to exercise ordinary care in making medical-necessity determinations.

At issue in *Rush Prudential* was whether Illinois could impose an independent-review process upon an HMO's medical-necessity determinations; rejecting the HMO's various challenges to the state IRO law, the Court held that the Illinois law was indeed saved from preemption.[26] As a threshold matter, the Court found that because HMOs without question assume risk (even though they might also do other things), they fall within the definition of "insurers." *Rush Prudential*, 536 U.S. at 367-70; *see also Pegram*, 530 U.S. at 218-19 (HMOs are

26. The Illinois Attorney General and Petitioners treated § 514(a) preemption as a given; Illinois argued the case entirely upon the insurance exception and never challenged whether § 514(a) applied at all. And it does not. *See* Part II, *supra*.

"risk-bearing organizations," because they generally "assume[] the financial risk of providing the benefits promised").

And even if CIGNA was acting as a third-party administrator, that status does not change the result; a state insurance law's possible incidental effects on non-risk-bearing entities do not suffice to remove it from the saving clause. *Rush Prudential*, 536 U.S. at 371 ("Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan."). *See also Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1476 n.1 (2003) (Kentucky any-willing-provider laws "apply to all HMOs, including HMOs that do not act as insurers but instead provide only administrative services to self-insured plans"; HMO activity in providing administrative services to self-insured plans "suffices to bring them within the activity of insurance for purposes of § 1144(b)(2)(A)").[27] In any event, Calad's original petition, which must be taken as true for purposes of determining removal jurisdiction, alleges that her membership in CIGNA's Exclusive Provider Program ("EPP") was "an insurance plan, not a self-funded plan." J.A. 184; *see also* Calad 5th Cir. Br. 6 (same). CIGNA conceded below that in this circumstance a "plaintiff's pleading controls whether removal is appropriate." J.A. 195.

The EEP appears to be at least a CIGNA-managed network of providers, doctors, and hospitals contracting with CIGNA, if not actually an HMO.[28] And it is also undisputed that CIGNA

27. Here, both Aetna and CIGNA fall under the jurisdiction of the Texas Department of Insurance, as evidenced by (among many other things) the form provider contracts each is required to file. Resp't App. A, B; *see also* J.A. 150.

28. CIGNA's status is the subject of a factual dispute: Calad's state-court petition asserted without objection that CIGNA was an HMO. (The United States' *amicus* brief in support of Petitioners also refers to Petitioners as "HMOs." Sol. Gen. Br. 29.) Though there is

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acts as a managed-care entity in making medical-necessity decisions communicated to its provider network; CIGNA stated, in its notice of removal, that Calad "did not qualify under *CIGNA*'s medical necessity criteria. . . ." J.A. 196 (emphasis added). *See also* CIGNA Br. 3 (medical-necessity determinations are made by "nurses and consultant physicians in the designated review organization"). Ryland, not CIGNA, is denominated as the Ryland Plan Administrator. J.A. 281. Aetna administers its "HMO" in deciding medical necessity in connection with its formulary. J.A. 25. ("This is a Group Agreement between Aetna U.S. Healthcare of North Texas, Inc. (hereinafter referred to as HMO". . .). That Aetna was not acting as the ERISA-plan administrator is further evidenced by Aetna's agreement with Davila's employer, which states that "[n]either party is an agent nor employee of the other." J.A. 31.

In *Kentucky Association*, the Court significantly (and unanimously) completed the change in McCarran-Ferguson analysis previously applied in the ERISA context by simplifying the inquiry it began in *Rush Prudential*. In determining whether a state law is saved under § 514(b)(2)(A), the Court imposes only two requirements: "First, the state law must be specifically directed toward entities engaged in insurance [citing *Pilot Life*, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), and *Rush Prudential*]. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." 123 S. Ct. at 1479. Because Kentucky insureds could not seek insurance from a closed network in exchange for a lower premium, "[t]he AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer." *Id.* at 1478.

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some evidence that Calad's employer had a self-funded plan, there are other indications that CIGNA was in fact acting as a managed-care entity in coordinating a provider network, not just administering a self-funded plan. In this procedural posture the complaint's allegations are presumed to be true and viewed in the light most favorable to the plaintiff, as CIGNA admitted below.

The Texas Act's liability provisions similarly affect risk arrangements, for two primary reasons, among many others. First, like the IRO provisions upheld in *Rush Prudential*, they "exclude[] insureds from joining an HMO" that would impose subjective medical-necessity criteria free from external, state-imposed ordinary-care criteria "in exchange for a lower premium." *Kentucky Ass'n*, 123 S. Ct. at 1476. Second, like *UNUM*'s notice-prejudice rule, which "dictates to the insurance company the conditions under which it must pay for the risk that it has assumed," *id.* at 1477 n.3, the Texas Act substantially affects the risk-pooling arrangement by dictating to HMOs and their employees and agents the conditions under which they must respond to the risks (illnesses) assumed—*e.g.*, employing that "degree of care" that a similarly situated person in the "same profession, specialty, or area of practice" (here, a pharmacist and a physician or nurse) would use. Texas Act § 88.001(10). *See also* J.A. 152-54 and n.19 (Aetna's argument that McCarran-Ferguson Act preempted plaintiffs' RICO claims in MDL litigation, as state insurance laws "do not merely regulate remedies for concededly wrongful conduct. Instead, they address the very core of state insurance regulation: what conduct by an insurer is (or is not) permissible. . . .").

Even before *Kentucky Association*, the Court observed—in rejecting an insurer's challenge to California's notice-prejudice rule—that if insurers "could displace any state regulation simply by inserting a contrary term in plan documents," the saving clause would be "virtually" read out of ERISA. *UNUM*, 526 U.S. at 376 and n.6 (recognizing that "applying the States' varying insurance regulations creates disuniformities for national plans," but that "such disuniformities are the inevitable result of the congressional decision to 'save' local insurance regulation") (internal punctuation, citation omitted). The same is true here: HMOs cannot displace state regulation of insurance and health-care matters by inserting a contrary term—making themselves the sole arbiter of medical necessity and then claiming effective

immunity from review of an erroneous decision—in documents that are not even the ERISA "plan."

B. The federal-law exception and the McCarran-Ferguson Act.

The concluding paragraph of § 514 provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States. . . ." One of those federal laws is of course the McCarran-Ferguson Act, 15 U.S.C. § 1012, which provides, in subsections (a) and (b), respectively, that "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation . . . of such business," and that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . ." Taken together, the concluding provision of § 514 and the McCarran-Ferguson Act further show Congress's overall intent to leave state insurance regulation squarely within the states' domain. *Metropolitan Life*, 471 U.S. at 744 n.21.

Congress spoke unequivocally when it saved state laws regulating the business of insurance from preemption; it provided that federal law—including the McCarran-Ferguson Act's clear reservation of insurance-related regulation to the states—remained unaffected by ERISA; and with its decisions in *Rush Prudential* and *Kentucky Association*, the Court has reaffirmed the primacy of state insurance regulation.

IV. Judicially implied preemption should not trump an express exception to preemption delineated by Congress.

A. Applying judicially implied complete preemption here ignores the plain text of both the saving clause and federal-law exception, and violates the separation of powers.

1. Starting with the *Travelers* trilogy in the mid-1990s, the Court curtailed the implication from its earlier rulings that § 514(a) "relates to" preemption had an infinite reach. Now foreclosed for several reasons from advancing previously all-encompassing "relates to" preemption under ERISA's only express-preemption clause, the HMOs urge judicially implied complete preemption under Section 502(a), and attempt to give judicially implied preemption the same infinite reach the Court has more recently found Congress never intended in § 514(a). If Petitioners' argument is adopted, Section 502 judicially implied complete preemption will now sweep away practically every state law, including those expressly saved from preemption.

It is to be hoped that Petitioners will concede that the Texas Act is a state insurance law saved from § 514 preemption under *Rush Prudential* and *Kentucky Association*. Petitioners are left asking for a doctrine created by judicial implication to override an express saving clause. Yet one cannot ignore the passage shortly following *Rush Prudential*'s comments anticipating a "forced choice" between a saving clause and *Pilot Life's* language about exclusive remedies: "We think, however, that [the HMO] overstates the rule expressed in *Pilot Life*." *Rush Prudential*, 536 U.S. at 378. *See also Taylor*, 481 U.S. at 67 (Brennan, J., concurring) ("I write separately only to note that today's holding is a narrow one.").

In fact, the United States' *amicus* brief in *UNUM* correctly recognized that the language in *Pilot Life* sometimes read to preempt even causes of action under laws regulating insurance was *dicta*, "unnecessary to *Pilot Life's* holding that the law at

issue there was not in any event an insurance regulation within the meaning of that provision." Br. of United States 20, 1998 WL 839957, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868). The Solicitor General went on to properly construe § 502 as not trumping the insurance saving clause: "Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be 'construed' to relieve or exempt any person from 'any law' of a State that regulates insurance." *Id.* at 23. Thus, according to the Government, "the insurance savings clause, on its face, *saves state law conferring causes of action or affecting remedies* that regulate insurance. . . ." *Id.* (emphasis added).

Of course, even under a broader reading *Pilot Life* and *Taylor* are not helpful to the HMOs in overcoming the insurance saving clause. *Pilot Life* and *Taylor* contain three holdings not applicable here: (1) The state's general law in each instance was not specifically directed toward the insurance industry and thus not saved as a "law regulating the business of insurance"; (2) the state law supplied additional remedies *only* for an inarguably duplicate claim for the continued withholding of benefits; and (3) the state law did not regulate areas and duties distinct from those found in ERISA. The Texas Act is distinguishable on all three points; the saving-clause language is clear.

2. Justice Frankfurter's salutary quote of Justice Holmes obtains: "[Previously] I was indiscreet enough to say I don't care what [the legislature's] intention was. I only want to know what the words mean." Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 Colum. L. Rev. 527, 538 (1947). Congress could of course have made these cases even easier if, in enacting the saving clause, it had said, "Do not preempt Texas's and other states' regulation of HMOs and their medical-necessity decisions," or, "Do not preempt the Texas Act." But the saving clause is just as explicit, and more expansive in its effect; Congress unequivocally preserved "*any law of any State*

which regulates insurance," and proceeded to define "State law" in § 514(c)(1) to mean "*all* laws . . . or other State action having the effect of law"—a formulation that clearly includes in its broad definition of "State law" private causes of action against risk-bearing or risk-adjusting entities, and other state enforcement devices constituting a state's "laws" regulating insurance.

The HMOs seek to add by judicial implication a phrase to the saving clause that Congress most assuredly did not include, given the unambiguous words actually used. Congress saved "any" and "all" "laws regulating the business of insurance" (and through the federal exception and the McCarran-Ferguson Act, "all laws of the several States which relate to the regulation" of the "business of insurance")—to which the HMOs would add "except for all state-law insurance remedies." Congress did not of course include any such phrase; and the judiciary should not rewrite the saving clause and the McCarran-Ferguson Act to do what Congress did not, because that is judicial legislation. "Were the power of judging joined with the legislative, the life and liberty of the subject would be exposed to arbitrary controul, for *the judge* would then be *the legislator*." The Federalist No. 47, at 326 (James Madison) (J. Cooke ed. 1961) (citation omitted).

If Petitioners were to prevail, four legislative actions—ERISA's saving clause, ERISA's federal-law exception, the McCarran-Ferguson Act, and the Texas Act—would be overridden by a judicially implied doctrine. The democratic will of Congress and state legislatures should not be frustrated by "implied" exceptions not founded in the congressional enactment, as this would (among other indignities) violate the Constitution's separation of powers. The Court has never gone so far with an implied exception to the plain text of an express saving clause.

3. Going beyond the saving clause's express text would also require concluding that Congress, without saying so anywhere in ERISA or its legislative history, implicitly negated

various existing state-law insurance remedies. In effect in late August of 1974 were at least 14 insurance statutes in at least 12 states that included separate remedial enforcement provisions; several provided a private cause of action. *See* S.D. Codified Laws § 58-33-46.1 (1974) (private right of action); 1973 Tex. Gen. Laws, ch. 22, sec. 3, art. 21.21, § 16 at 395-6 (since codified at Tex. Ins. Code Ann. art. 21.21, § 16 (2003)) (private right of action); Kan. Stat. Ann. § 40-3111 (1974) (private right of action); 215 Ill. Comp. Stat. 5/155 (2003) (formerly Ill. Rev. Stat. 1967, ch. 73, par. 767) (private right of action); 215 Ill. Comp. Stat. 5/431 (1967); Tenn. Code Ann. § 56-7-105 (1955) (private right of action); Mo. Ann. Stat. § 375.420 (1939) (private right of action); Mo. Ann. Stat. § 375.942 (1959); Ga. Code Ann. § 33-6-8 (1960); Ind. Code § 27-4-1-6 (1947); Pa. Stat. Ann. tit. 40, § 1171.11 (1974); Conn. Gen. Stat. § 38a-817 (2003) (formerly Conn. Gen. Stat. § 38-62 (1971); Ark. Code Ann. § 23-66-210 (1959); Mass. Gen. Laws Ann. ch. 176D, § 10 (1972).

One cannot infer from the state insurance regulatory landscape extant in 1974 that Congress somehow thought state laws regulating insurance lacked remedies provisions. To exclude those state remedies from the scope of the insurance saving clause in 1974, Congress had to say so. It did not.

4. There is of course another presumption closely related to the one against preemption, both of which have their roots in notions of federalism, and which further shows that allowing judicial implication to trump express exceptions to preemption would be error in these cases: the presumption that every law enacted by a state government is constitutional. *E.g.*, *Kelley v. Johnson*, 425 U.S. 238, 247 (1976) (noting presumption of legislative validity concerning matters within state's police power); *Atchison, T. & S.F. R. Co. v. Matthews*, 174 U.S. 96, 104 (1899) ("It is . . . a maxim of constitutional law that a [state] legislature is presumed to have acted within constitutional limits"). These rules derive from the states' role as separate sovereigns in our federal system. *See supra* Part I.B; *see also*

Geier, 529 U.S. at 907 (Stevens, J., dissenting) (noting that "the structural safeguards inherent in the normal operation of the legislative process operate to defend state interests from undue infringement"; the presumption "serves as a limiting principle that prevents federal judges from running amok with our potentially boundless (and perhaps inadequately considered) doctrine of implied conflict preemption . . ."). The Texas Act must be presumed to be—and is—a constitutional exercise of Texas's police power in our federal system.

B. The Court's rare finding of implied conflict preemption, but never complete preemption and thus removability, when a saving clause is present.

1. In this Court, judicially implied preemption has never supported removal where a statute's saving clause applied.[29] Only rarely has the Court implied even *conflict* preemption in the face of a saving clause. The uncommon occasions on which the Court has implied defensive conflict preemption in the presence of a saving clause supplies a ground for decision here that yields no reason for implied preemption to trump the insurance saving clause or the McCarran-Ferguson Act.

The Supremacy Clause nullifies "saved" state law only where that law either prevents or frustrates the accomplishment of an explicit federal objective, or makes it impossible for private parties to comply with both state and federal law. *See*, *e.g.*, *Geier*, 529 U.S. at 873-74; *United States v. Locke*, 529 U.S. 89 (2000)

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29. Though *Rush Prudential* pronounced that a plaintiff who succeeded in getting an IRO reviewer to agree that a particular treatment was medically necessary was then left with a § 502(a)(1)(B) action to recover "benefits," the plaintiff did not cross-petition the Seventh Circuit's decision that her removed claim to enforce the IRO decision was such a claim. *See* Br. of the American Medical Ass'n *et al.* as *Amici Curiae* 19, *Rush Prudential*, 536 U.S. 355 (No. 00-1021). Consistent with the plaintiff's acquiescence in that holding, the parties' briefing simply assumed that § 502(a)(1)(B) applied; the dispute revolved around whether the IRO provisions impermissibly added to ERISA's remedies, with the Court holding that they did not.

(finding various state tanker-related regulations preempted by comprehensive federal regulatory scheme governing tankers but concluding that other state regulations might not be preempted); *American Tel. & Tel. Co. v. Central Office Tel., Inc.*, 524 U.S. 214, 227-28 (1998) (common-law right is not "saved" if it would be "absolutely inconsistent with the provisions of the act"); *Freightliner Corp. v. Myrick*, 514 U.S. 280, 287, 289 (1995) (federal act contained both express-preemption provision and saving clause, but holding no implied preemption where federal standard regulating ABS devices on vehicles did not exist, thus no frustration of federal law or impossibility of complying with both federal and state law); *Ouellette*, 479 U.S. at 494, 497 (holding that federal Clean Water Act, which extensively regulates water pollution, does not preempt pollution law of source state, thereby giving force to an express saving clause while finding preemption of another state's nuisance law); *Chicago and North Western Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311 (1981) (holding that Interstate Commerce Act's exclusive regulation of abandoned rail lines impliedly preempted state-law claim concerning same subject).

The HMOs do not argue that it is impossible for them to comply with both ERISA and the Texas Act, as indeed it is not. *Cf. John Hancock Mut. Life*, 510 U.S. at 98 ("ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized or accommodated").

2. Without a conflict—that is, an impossibility of complying with both ERISA and the Texas Act—the HMOs are left to argue for judicially implied, saving-clause-trumping preemption on a more amorphous basis from the penumbras of ERISA's "scope and purpose," despite the lack of any substantive ERISA regulation of HMOs' medical decisions. But ERISA's explicit scope and purpose do not help the HMOs in their endeavor.

ERISA's objectives are found most clearly in its opening section, 29 U.S.C. § 1001, which focused on the then-prevailing

situation in which employees were "losing anticipated *retirement* benefits" (emphasis added) and declared ERISA's policy to be the protection of "the interests of participants in employee benefit plans and their beneficiaries." Subtitle B, 29 U.S.C. §§ 1021-1144 deals heavily with *pension-plan* regulation, and says little about welfare plans. Part 4 ("Fiduciary Responsibility") of that subtitle, though not expressly limited to pension plans (*cf.* 29 U.S.C. §§ 1051, 1081), is significantly limited by *Pegram* to have any arguable application to HMOs, which are not employers, plan sponsors, or fiduciaries in this context. Section 502(a)(1)(B) is also within Subtitle B, but § 502 contains further language illuminating congressional intent regarding the boundaries of field preemption. Section 502(d)(2), for example, provides that "[a]ny money judgment" is "enforceable only against the plan as an entity," and is "not enforceable against any other person unless liability . . . is established in his individual capacity [*i.e.*, as a fiduciary] under this subchapter." 29 U.S.C. § 1132(d)(2).

In contrast to pension plans, an area without "strong state-law roots," ERISA does not comprehensively regulate non-pension plans; welfare-plan benefits (such as health care), "long governed under the states' police powers, have never been viewed as a peculiarly federal concern." Bogan, *supra* n.23, 74 Tul. L. Rev. at 956-57 (citing *Travelers*). The Court's observation that ERISA is a "comprehensive and reticulated statute" (*e.g.*, *Alessi*, 451 U.S. at 510) initially arose—quite accurately—in the context of pension-plan cases, but extending this formulation to cases involving non-pension benefits is demonstrably wrong even if the benefit is seen not as payment of the HMO membership dues or premiums, but as the health care the HMOs agree to arrange for and provide.

In addition, early versions of ERISA included removal provisions, but the enacted version omitted them, without any explanation in the Conference Report. *See*, *e.g.*, H.R. 2 at 96, *reprinted at* 1 Leg. Hist. at 188 (authorizing Secretary of Labor or ERISA-plan participant to remove under certain

circumstances); S.4 at 196, *reprinted in* 1 Leg. Hist. at 584 (same); amendment to S.4 at 222-23, *reprinted in* 1 Leg. Hist. at 1492-93 (authorizing Secretary to remove); H. Rep. No. 93-533 at 155-56, *reprinted in* 2 Leg. Hist. at 2335-36 (allowing any party to remove); H.R. 2 at 151, *reprinted in* 3 Leg. Hist. at 4048 (also allowing any party to remove).

The absence of any removal provision in the final version of ERISA is consistent with Congress's grant of concurrent jurisdiction to state and federal courts.[30] And it is also consistent with Congress's statement that it intended, with ERISA's enforcement provisions, "to provide the *full range of legal and equitable remedies available in both state and federal courts* and to remove jurisdictional and procedural obstacles which in the past appear to have hampered . . . recovery of benefits due to participants." Senate Comm. on Labor and Public Welfare, S. Rep. No. 93-127 at 35, *reprinted in* 1 Leg. Hist. at 621 (emphasis added). Nowhere within ERISA's scope, purpose, or structure did Congress signal an intent to preempt state regulation of health-care matters generally, and of HMO medical decisions specifically.

3. It bears repeating: declining to apply judicially implied complete preemption to Respondents' claims in no way requires that *Pilot Life* and *Taylor* be overruled, but merely left unexpanded into an area that Congress never intended to preempt.

The HMOs bridge the chasm between the actual holdings of *Pilot Life* and *Taylor* on the one hand and the Texas Act on the other by a precariously cantilevered contraption: ignore the strong presumptions against preemption and in favor of constitutionality; ignore the statutorily expressed overriding purpose of ERISA to protect beneficiaries; ignore the well-pleaded-complaint rule; ignore Congress's explicit saving

30. Section 502(e)(1), 29 U.S.C. § 1332(e)(1), is thus unlike LMRA § 301, 29 U.S.C. § 185(a), which provides that "[s]uits for violation for contracts between an employer and a labor organization . . . may be brought in any district court of the United States. . . ."

clause; re-characterize the facts to fit broad *dicta* about "processing benefits"; and ignore the holdings of *Pegram* and *Rush Prudential*. Cantilevers collapse if not precisely engineered so they do not project out too far. The HMOs' contraption fails because it extends too far, by ultimately asking the Court to make law, not interpret it, something that happens when a judge "extends his precedents, which were themselves the extension of others, till, by this accommodating principle, a whole system of law is built up without the authority or interference of the legislator." Robert Rantoul, Oration at Scituate (July 4, 1936), *quoted in* Kermit L. Hall *et al.*, American Legal History 317, 318 (1991). Just so here, if judicially implied preemption is allowed to overcome the saving clause's plain text.

Stare decisis is honored by following *Pilot Life* and *Taylor* when there is a truly duplicate claim for ongoing withholding of benefits against an ERISA plan or fiduciary. If the state law substantively regulates medical decision-making or falls within the insurance saving clause and the McCarran-Ferguson Act exception, though, it is not preempted, and at a minimum there is no removal preemption. This does no violence to *Pilot Life* and *Taylor*, while giving full effect to what Congress did and did not say.

V. A holding of no implied complete preemption here would not undermine uniformity, disturb "settled expectations" or increase insurance costs.

1. The illogic of making "uniformity" the *sine qua non* of ERISA preemption in the case of employee-welfare benefits as opposed to pension benefits is shown principally by the fact that ERISA does not set out detailed requirements for the former, as it does with the latter. If Congress meant to invest ERISA with some substantive principles concerning medical necessity, thus justifying wholesale preemption of state health-care law, it failed miserably; both the statute and Department of Labor regulations are completely mute on the point.

Too, there are thousands of health-insurance and managed-care entities operating in the United States, *see* Rosenblatt at

545, each imposing its own (disuniform) definition of "medical necessity." *Compare* J.A. 54-55 (Aetna's definition of medical necessity) *with* J.A. 236 (CIGNA's definition); *see also* J.A. 300 (Aetna's statement from brief in Florida MDL litigation that "[t]he precise presentations made to health plan members about the scope of 'medically necessary' care available to them vary considerably," and quoting various state statutes defining medical necessity differently); J.A. 301 (similar excerpt from CIGNA brief). A "uniform" idea of medical necessity is paradoxical when it turns entirely on the vagaries of which HMO a patient happens to belong to. *See also* Chamber Br. 20-21 (recognizing that through valid IRO mechanisms, states can impose as many as 50 different standards of medical necessity).

Part of the difficulty surely lies in the very nature of medical-necessity decision-making: what is appropriate for one patient may not be so for the next, a point the Department of Labor made in its *Pappas* brief: "[A]llowing state law challenges to medical judgments made in the context of an HMO's mixed treatment and eligibility decisions should not defeat ERISA's goal of ensuring that plans and plan sponsors would be subject to a uniform body of benefits law. . . ." DOL Br., 2000 WL 34016555 at *13 (Sept. 22, 2000), *Pappas*, 768 A.2d 1089. State tort law "would not threaten uniformity because the determination is an individualized decision that dictates nothing regarding the treatment to be afforded in the next individualized case." *Id.* at *14 (internal quotation marks, citation omitted). *See also* Stempel, *supra* n.14, 36 Tort & Ins. L. J. at 696-97 (ERISA stresses substantive remedies to protect retirement benefits more than it does uniformity). Justice Frankfurter had it exactly right when he cautioned against "the deceptive lure of certainty and comprehensive symmetry," recognizing that there are "demands more inclusive than those for mechanical uniformity." *Wilburn Boat Co. v. Fireman's Ins. Co.*, 348 U.S. 310, 324 (1955) (Frankfurter, J., concurring).

2. It is of course not only HMOs and employers that have an interest here: millions of patients also have "settled

expectations," Aetna Br. 41, that their state governments will protect their safety when it comes to medical decision-making. More fundamentally, the states and their citizens, litigants, and lower courts have settled expectations as well that constitutional principles of federalism will be respected.

And it was not until 1992 that a court first used ERISA to immunize a utilization-review entity from its medical decisions. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). Beginning three years later, with the *Travelers* trilogy, the Court began to cast doubt upon notions of sweeping ERISA preemption. Since *Corcoran*, numerous courts have struggled mightily with if and how to apply preemption to HMOs, with disparate results. *E.g.*, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam); *Pappas*, 768 A.2d 1089; *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied sub nom. U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003), *petition for cert. filed*, 72 U.S.L.W. 3310 (U.S. Oct. 28, 2003) (No. 03-649). This is but a small sample of the many contradictory HMO ERISA-preemption cases across the country—hardly the stuff of "settled expectations."

3. Empirical data show that Petitioners' claim that deferring to Texas's (and other states') traditional role in regulating health-care and insurance matters would increase health-care costs is wrong. The Congressional Budget Office estimated that under the then-proposed Patients' Bill of Rights Act of 1998, the effect of formally and explicitly extinguishing ERISA preemption would result in only a 1.2% increase in health-plan premiums. Congressional Budget Office Cost Estimate—H.R. 3605/ S. 1890, *available at* www.cbo.gov/showdoc.cfm (July 16, 1998). *See also* Kaiser Family Foundation, "Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS, Other Large Public Employers, and a Large California Health Plan," *available at* www.kff.org/statepolicy/1415-erisa.cfm (June 1998) (showing costs of no more than $.13 per

member per month attributable to public employees' existing ability to sue managed-care plans); CBO, *Limiting Tort Liability for Medical Malpractice* 7, *available at* ftp://ftp.cbo.gov (Jan. 8, 2004) (available evidence "does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency."). Further, even though ERISA has never been construed to create HMO immunity in the case of state, county, and school-district employees, there is no evidence that premiums for those classes of insureds differ from those paid by private-sector insureds receiving HMO membership through an employer.

Texas's experience following the 1997 enactment of the Act is particularly instructive. The American Medical Association, for example, noted figures from the Texas Department of Insurance showing that average per-member per-month HMO premiums fell 1.3% in 1998, the year after the Texas Act was passed. They rose nearly 5% in 1999 and about 9% in the first three quarters of 2000. In contrast, HMO premiums nationwide rose an average of 1.6% in 1998, 5.4% in 1999, and 9.6% in 2000. *Texas Trial: HMO Liability Law*, *available at* www.ama-assn.org/amednews/2001/05/28/gvsa0528.htm (May 28, 2001). *See also* Mark A. Hall & Gail Agrawal, "The Impact of State Managed Care Liability Statutes," *Health Affairs*, Vol. 22, Issue 5, 138-145 (2003) (study of six states, including Texas, that have adopted varying types of managed-care patient-protection laws shows that fears of "flood of litigation" that would increase health-insurance costs by roughly 5 percent has not been "borne out by experience."). Even if the tocsins that HMOs routinely sound in response to laws holding them accountable were factually based, such warnings do not justify the draconian result Petitioners here seek of leaving patients with no way to recover for HMO medical malpractice.

As well, United HealthCare, the nation's second-largest managed-care company, decided in 1999 to virtually eliminate prospective medical-necessity utilization review. *See* Comment,

What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through a System of External Appeals, 149 U. Pa. L. Rev. 873, 915 (2001). From United HealthCare's decision, the apparent inefficiencies associated with utilization review can reasonably be viewed as at least as important in driving premium costs as any (unfounded) concerns about potential litigation.

Finally, going over the head of the Texas Legislature for judicially imposed tort reform is hardly necessary. Since 1994, Texas has passed numerous pieces of tort-reform legislation limiting plaintiffs' recovery, limiting access to the courts, eliminating claims, and capping recoverable damages. Resp't App. D (listing 45 examples of Texas tort-reform legislation passed in the last decade). If HMOs do in fact become subject to disproportionate verdicts and judgments, Texas has shown itself without peer in the area of tort reform. The Legislature's willingness to enact multiple tort reforms should at least give pause when one considers that the Texas Act contains the only significant new cause of action Texas has adopted in the last decade. Even in a decade of dramatic tort reform, the Legislature determined that the problem of lack of HMO accountability for defective medical decisions was particularly acute.

CONCLUSION

In explaining the need for the Texas Act, sponsoring state senator David Sibley said this:

> Health care delivery in the United States has changed, it's no longer the same as it was. * * * You . . . have a third party [HMO] now who has . . . insinuated themselves into the treatment room and into the operating room, and into the examination room. * * * *If people are gonna stand in the shoes of the doctor and make decisions that chart the course of treatment, I think they oughta be held accountable. . . .* [Resp't App. C, transcript of March 17, 1997, Texas Senate proceedings on S.B. 386 at 1, 5 (emphasis added).]

Aetna and CIGNA want *not* to be held accountable, and they seek that result by asking the Court to render the Texas Act a nullity with regard to HMO medical-care decisions, and through contorted application of a federal employee-protection statute that was never meant, under any construction, to usurp a state's right to regulate medical-care and insurance issues within its border. And this is not, contrary to Petitioners' suggestion, an issue for Congress to fix. It can and should be resolved by doing nothing more than applying fundamental principles of statutory construction.

For all the reasons discussed, the Fifth Circuit's decisions below should be affirmed.

Respectfully submitted,

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Attorneys for Respondents

APPENDIX A — CIGNA CONTRACT PROVISIONS SAMPLE

Excerpts of Cigna Form Contract Provisions[1]

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

The commissioner of Insurance, as the chief administrative and executive officer and custodian of records of the Texas Department of Insurance has delegated to the undersigned the authority to certify the authenticity of documents filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

Therefore, I hereby certify that the attached documents are true and correct copies of the documents described below. I further certify that the documents described below are filed with or maintained by or within the custodial authority of

---

[1] Cigna contract provisions quoted in Appendix "A" (pages 1a-8a) of this Appendix are *excerpts* from the certified original documents filed with the Texas Department of Insurance ("TDI") by Cigna Healthcare of Texas, Inc. in 1999. Aetna contract provisions quoted in Appendix "B" (pages 9a-25a) are *excerpts* from the certified original documents filed with TDI by Aetna Health, Inc., in 1999 and 2000. Appendix "E" is the Texas Act § 88.001, *et seq*. Cigna and Aetna do not object to the inclusion of the materials in Respondents' Appendices "A," "B," "C" and "D" even though they do not appear in the record below (just as Aetna's Formulary does not appear in the record below, see Aetna App. 26a-40a).

the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

The certified documents consist of complete copies of form filings submitted by Cigna Healthcare of Texas, Inc. in 1999.

This certification does not include records relevant to an inquiry, if any, by the Texas Department of Insurance's Insurance Fraud Unit which are confidential pursuant to Tex. Ins. Code art. 1.10D. § 5(a) and an Op. Tex. Att'y Gen. No. OR95-1536 (1995).

IN TESTIMONY WHEREOF, witness my hand and seal of office at Austin, Texas, this 17th day of December, 2003.

JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

[seal]

BY: /s/
Olga Escobedo, Director
HMO Compliance/URA/IRO Section
HMO Division
Life, Health & Licensing Program

[CIGNA's] MANAGED CARE ALLIANCE AGREEMENT

PARTIES _____

This Agreement is by and between CIGNA HealthCare of _____, Inc. ("CIGNA") and _____ ("MCA") and is entered into as of the Effective Date.

* * *

I. DEFINITIONS

* * *

Medically Necessary means services and supplies which under the terms of the applicable Service Agreement are "Medically Necessary. Covered Services must be Medically Necessary." [pages 2, 3]

* * *

ELECTION TO PARTICIPATE WITH CIGNA HEALTHCARE OF _____ AND AFFILIATES

* * *

3. **CIGNA Programs, Policies and Procedures**. You agree to cooperate with, and abide by CIGNA's programs, procedures, and policies, including but not limited to those regarding billing, provider credentialing, utilization

management, quality assurance, medical record keeping and Participant grievances and appeals. [page ETP-1]

* * *

EXHIBIT B
HMO PROGRAM ATTACHMENT – CAPITATION
UTILIZATION MANAGEMENT

1. MCA will establish a Utilization Management program (the "UM Program") in accordance with CIGNA's standards, NCQA standards or the standards of another appropriate accrediting body designated by CIGNA, and Program Requirements. MCA shall maintain any licensure required in connection with its UM Program activities, and its UM Program shall comply with all requirements of applicable laws.

2. MCA's UM Program shall seek to assure that health care services provided to Participants are Medically Necessary and will include, but not be limited to the following: management of referrals between the Primary Care Physician and specialist, prior authorization and case management of outpatient facility based services, prior authorization and case management of inpatient services, discharge planning, major condition case management, and utilization information management.

* * *

6. CIGNA shall have the right to audit MCA's utilization management activities upon reasonable prior notice. MCA shall cooperate with any such audits.

* * *

9. The parties acknowledge and agree that CIGNA or Payor shall have final decision making authority with regard to appeals of utilization management decisions. [page HMO-EXB – 1]

MEDICARE PROGRAM ATTACHMENT
TO
[CIGNA'S] MANAGED CARE ALLIANCE
AGREEMENT
(CAPITATION)

EXHIBIT B

MEDICARE PROGRAM ATTACHMENT –
CAPITATION
UTILIZATION MANAGEMENT

(delegation of utilization management)

1. MCA will establish a Utilization Management program (the "UM Program") in accordance with CIGNA's standards, NCQA standards or the standards of another appropriate accrediting body designated by CIGNA, and Program Requirements. MCA shall maintain any licensure required in connection with its UM Program

Appendix A

activities, and its UM Program shall comply with all requirements of applicable laws.

2. MCA's UM Program shall seek to assure that health care services provided to Participants are Medically Necessary and will include, but not be limited to the following: management of referrals between the Primary Care Physician and specialists; prior authorization and case management of outpatient facility based services, prior authorization and case management of inpatient services, discharge planning, major condition case management, and utilization information management.

* * *

6. CIGNA shall have the right to audit MCA's utilization management activities upon reasonable prior notice. MCA shall cooperate with any such audits.

* * *

9. The parties acknowledge and agree that CIGNA or HCFA, as applicable, shall have final decision making authority with regard to appeals of utilization management decisions. [pages EXB – 1, EXB – 2]

Appendix A

EXHIBIT B
MEDICARE PROGRAM ATTACHMENT –
CAPITATION
UTILIZATION MANAGEMENT
(no delegation of utilization management)

MCA and its Represented Providers shall comply with the requirements of CIGNA's Utilization Management program . . . [page EXB – 1]

[CIGNA's]
PARTICIPATING PHARMACY AGREEMENT

PARTIES

THIS AGREEMENT is by and between CIGNA HealthCare of Texas, Inc. ("Healthplan"), and the Pharmacy ("Pharmacy") whose name appears below and is entered into as of the Effective Date.

* * *

2. *Pharmacy's Responsibilities*

* * *

i. Pharmacy will cooperate and participate in Healthplan's quality assurance, utilization review, and grievance programs, which are described in Program Requirements. [pages 1, 2, 3]

APPENDIX B — AETNA CONTRACT PROVISIONS SAMPLE

Excerpts of Aetna Form Contract Provisions

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

The commissioner of Insurance, as the chief administrative and executive officer and custodian of records of the Texas Department of Insurance has delegated to the undersigned the authority to certify the authenticity of documents filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

Therefore, I hereby certify that the attached documents are true and correct copies of the documents described below. I further certify that the documents described below are filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

The certified documents consist of copies of several form filings that were filed by Aetna Health, Inc., in 1999 and 2000.

This certification does not include records relevant to an inquiry, if any, by the Texas Department of Insurance's Insurance Fraud Unit which are confidential pursuant to Tex. Ins. Code art. 1.10D. §5(a) and an Op. Tex. Att'y Gen. No. OR95-1536 (1995).

Appendix B

IN TESTIMONY WHEREOF, witness my hand and seal of office at Austin, Texas, this 17th day of December, 2003.

JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

[seal]

BY: _____
Olga Escobedo, Director
HMO Compliance/URA/IRO Section
HMO Division
Life, Health & Licensing Program

Appendix B

1. Documents filed in 2000

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You" or "Physician"), will furnish Primary Care Services and arrange for and coordinate the provision of other health services to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page -1-]

* * *

Appendix B

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Physician and Company of providing Members with access to and promotion of quality health care services. Physician shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS®") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations. Company will provide ninety (90) days prior written notice of material

changes in policies and procedures. In addition, Physician shall participate in Company's preventive care program or implement an effective preventive care program consistent with Company's criteria and policies, for which Physician shall be compensated in accordance with the Physician Compensation Model as described in the Compensation Schedule.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Providers.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission to notify the Company thereof. [pp. 4,5]

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] FACILITY AGREEMENT

* * *

4.0 COMPLIANCE WITH COMPANY RULES, POLICIES AND PROCEDURES

4.1 Compliance and Participation. Facility shall comply fully with the rules, policies and procedures that Company has established or will establish, including but not limited to, those regarding: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, and referral process or protocols; (c) claims payment review; (d) Member grievances; (e) provider credentialing; and (f) electronic submission of claims and other data required by Company. Facility shall comply with and be bound by

Appendix B

the Participation Criteria set forth in the **Participation Criteria Schedule.** Facility acknowledges and agrees that failure to comply with Company's rules, policies and procedures may adversely affect any compensation due hereunder and could lead to sanctions including, without limitation, termination of this Agreement. Company will provide ninety (90) days prior written notice of material changes in policies and procedures.

4.2 *Utilization Review.* Company utilizes systems of utilization review/quality improvement/peer review consistent with applicable federal and state laws to promote adherence to accepted medical treatment standards and to encourage Participating Providers to control medical costs consistent with sound medical treatment. To this end, Facility agrees:

a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) with respect to all Members. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Providers.

b) To provide telephone notice to Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services.

c) To provide clinical data and information to Company as is necessary to permit Company to conduct utilization review.

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d) To permit a Company home care coordinator to assist in on-site assessments of Members for purposes of discharge planning, when required by Company.

e) To allow Company to conduct concurrent on-site review, when required by Company.

f) To provide upon Company's request complete copies of Members' medical records.

(g) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment.

Noncompliance with any requirements of this Section 4.2 will relieve both Payors and Members from any financial liability for all or any portion of the services provided. [pages 4, 5]

Appendix B

[AETNA's] SPECIALIST PHYSICIAN AGREEMENT

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Physician and Company of providing Members with access to and promotion of quality health care services. Physician shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** and Company's then-current Policies regarding, among other things: (a) quality improvement/management/ assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) Physician credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"),

Appendix B

Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations. Company will provide ninety (90) days prior written notice of material changes in policies and procedures.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

Appendix B

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment. [page -5-]

2. Documents filed in 1999

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You" or "Physician"), will furnish Primary Care Services and arrange for and coordinate the provision of other health services to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance

Appendix B

organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page 1]

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Provider and Company of providing Members with access to and promotion of quality health care services. Provider shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** (attached hereto and made a part hereof) and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS®") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on

Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs and decisions. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria) to the fullest extent possible.

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission to notify the Company thereof. [pages -4-, -5-]

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] SPECIALIST PHYSICIAN AGREEMENT

Dear Specialist Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You", "Physician" or "Physician"), will furnish Covered Services in the specialized field of _____ (hereinafter called "Specialty") to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the

quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page 1]

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Provider and Company of providing Members with access to and promotion of quality health care services. Provider shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** (attached hereto and made a part hereof) and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS") and similar data collection and reporting; and (i) information collection and reporting required

or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

Appendix B

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment. [page 5]

APPENDIX C — EXCERPTS FROM THE TEXAS LEGISLATIVE HISTORY OF S.B. 386

TEXAS SENATE STAFF SERVICES
PAS/108/FLSB386.T1/040497
75TH LEGISLATIVE SESSION
EXCERPT: SENATE BILL 386
MARCH 17, 1997
TAPE 1

1

(Senator Zaffirini Presiding)

PRESIDENT: Chair recognizes the Senator from McLennan County for a motion on the Committee Substitute for Senate Bill 386.

SIBLEY: Thank you Madam President, Members. . . . Health care delivery in the United States has changed, it's no longer the same as it was. . . . You know you have a third party now who has put themselves – having insinuated themselves into the treatment room and into the operating room, and into the examination room.

AG 01522

5

SIBLEY: . . . If people are gonna stand in the shoes of the doctor and make decisions that chart the course of treatment, I think they oughta be held accountable . . .

AG 01526

APPENDIX D — SELECTED TEXAS "TORT REFORM" PROVISIONS ADOPTED IN THE LAST DECADE

Selected "Tort Reform" Provisions Adopted by Texas Legislature and Texas Governor Since 1994

2003

House Bill 4-revised Civil Practice and Remedies Code
Plaintiff reimburses Defendant's attorney's and expert witness fees if Plaintiff refuses settlement and the verdict does not exceed the offer of settlement.

Instead of joining a responsible third party, responsible third party may be designated, which can be anonymous if criminal conduct is involved.

Created rebuttable presumptions for medicines and other products that provide manufacturer immunity from liability for compliance with government standards.

Capped non-economic damages, which include losses for disfigurement, pain and suffering, and impairment, at $250,000 for individual practitioners and $250,000 per single health care institution, not to exceed $500,000.

Decreased the amount of time that medical malpractice Plaintiffs have to file mandatory expert report and eliminated the option for plaintiffs to file a bond in lieu of providing an expert report.

Permits jury to know whether plaintiff was wearing a seat belt for the purpose of allocating fault and determining the cause of damages.

Limits liability of hospitals that provide charity care services.

Requires unanimous verdict of jury to award punitive damages. H.B. 4, 78th Leg., Reg. Sess. (Tex. 2003).

House Joint Resolution 3
Constitutional amendment authorizes legislature to set limits on all damages, except economic damages. H.J.R. 3, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 408–revised Civil Practice and Remedies Code
Increased the number of landowners who receive limited liability under Civil Practice and Remedies Code. H.B. 408, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 705–revised Civil Practice and Remedies Code
Created a rebuttable presumption of no negligence for in-home service companies and residential delivery companies in cases involving criminal acts of employees. H.B. 705, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 1699–revised Civil Practice and Remedies Code
Immunized contractors who construct or repair highways for Dept. of Transportation for personal injury damage or death if the contractor complies with contract documents. H.B. 1699, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 3439–revised Civil Practice and Remedies Code
Immunized non-compensated healthcare providers from liability for physical exams and screenings at school. H.B. 3439, 78th Leg., Reg. Sess. (Tex. 2003).

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Senate Bill 313–revised Civil Practice and Remedies Code
Protects endowment of not-for-profit religious nursing facilities for payment of damages in civil lawsuits. S.B. 313, 78th Leg., Reg. Sess. (Tex. 2003).

2001
Senate Bill 731–amended Non-Profit Corporation Act
Negated liability of an officer of a non-profit corporation. S.B. 731, 77th Leg., Reg. Sess. (Tex. 2001).

Senate Bill 583–amended Property Code
Permits the filing of liens for services of emergency room physicians. S.B. 583, 77th Leg., Reg. Sess. (Tex. 2001).

1999
House Bill 747–amended the Medical Practice Act
Expanded the medical peer review committee definition. H.B. 747, 76th Leg., Reg. Sess. (Tex. 1999).

House Bill 580–amended Health and Safety Code
Limited the liability for use of a defibrillator while providing emergency care. H.B. 580, 76th Leg., Reg. Sess. (Tex. 1999).

House Bill 1058–amended Civil Practice and Remedies Code
Limits liability of a municipality for specific recreational activities. H.B. 1058, 76th Leg., Reg. Sess. (Tex. 1999).

Senate Bill 717–amended the Civil Practice and Remedies Code
Limits right to bring suit against firearm or ammunition manufacturers, trade associations, or sellers. S.B. 717, 76th Leg., Reg. Sess. (Tex. 1999).

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1997
House Bill 3–amended Health and Safety Code
Provided limited liability for doctors and officers of Healthy Kids Corporation. H.B. 3, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 21–revised Civil Practice and Remedies Code
Provided limited liability for those who donate medical devices to non-profit organization. H.B. 21, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 680-amended Education Code
Provided limited liability for those who donate fire control or rescue equipment to the Texas Forest Service. H.B. 680, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 768–amended Labor Code
Provided additional protections for employers in discrimination claims raising from former employees who allege discharge was related to worker's compensation claim. H.B. 768, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 785–revised Civil Practice and Remedies Code
Provided hospital districts and other taxing entities in non-urban counties right to venue in their home county. H.B. 785, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 1180–amended Natural Resources Code
Provided limited liability for those who install and service liquified petroleum gas systems in motor vehicles. H.B. 1180, 75th Leg., Reg. Sess. (Tex. 1997).

Appendix D

House Bill 2120–amended Transportation Code
Defined motorist's responsibility in railroad crossing accidents. H.B. 2120, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 2664–amended Civil Practice and Remedies Code
Limited liability of agricultural property owners whose land is used for recreational purposes. H.B. 2664, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 3087–amended Civil Practice and Remedies Code
Provided protection for defendants against individual with a history of filing litigation. H.B. 3087, 75th Leg., Reg. Sess. (Tex. 1997).

1995

Senate Bill 28–amended Civil Practice and Remedies Code.
Established uniform comparative bar for claimants at greater than 50% in causes of action based on tort, raised the bar by creating several liability where the responsibility of a defendant is greater than 50%, changed joint and several liability for intentional torts to only specified offenses in the Penal Code and permitted a defendant to join third parties and have responsibility submitted jury.

Property owner used for business purposes is liable for injuries to contractors and their employees occurring on the property if the owner has actual knowledge of dangerous condition and exercises control over the manner in which the work is conducted. S.B. 28, 74th Leg., Reg. Sess. (Tex. 1995).

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Senate Bill 25–amended Civil Practice and Remedies Code.
Gross negligence definition replaced with malice definition.

Placed limits on recovery of exemplary damages for fraud, malice and conduct constituting gross neglect in death cases to the greater of $200,000 or two (2) times economic losses plus not more than $750,000 of non-economic losses.

Increased the burden of proof from preponderance of the evidence to clear and convincing evidence for exemplary damages.

Limited request to bifurcate a trial to defendants only.

Limited liability for criminal acts to specific situations, including where the criminal is the defendant and where criminal is an employee of defendant.

Permits jury to consider net worth of defendant in awarding exemplary damages. S.B. 25, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 971–amended Texas Revised Civil Statute
Enhanced requirements for Plaintiffs to either file a bond within 90 days of filing suit or an expert report per defendant. Within 180 days of filing suit, plaintiffs must file an expert report pertaining to each health care defendant or be dismissed and subject to sanctions, including attorney's fees and forfeiture of security.

Defined expert qualifications of a physician who may testify as an expert witness in a health care liability claim.

Appendix D

Eliminated prejudgment interest on future damages. H.B. 971, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 668–added a provision to the Deceptive Trade Practices Act
Exempted claims based on rendition of professional services.

Unless defendant acted knowingly, all personal injury and wrongful death damages are excluded. Consumer is limited to economic losses unless the conduct was committed knowingly. Prejudgment interest is excluded on future damages and discretionary damages, trebling of actual damages is discretionary if defendant acted knowingly, mental anguish damages can be trebled only if act was intentional. H.B. 668, 74th Leg., Reg. Sess. (Tex. 1995).

Senate Bill 31–amended the Civil Practice and Remedies Code
Permits sanctions against the party, party's counsel or both for filing frivolous pleadings or motions. S.B. 31, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 383–amended Texas Tort Claims Act
Expanded to provide protection to elected or appointed officials and employees of local government. H.B. 383, 74th Leg., Reg. Sess. (Tex. 1995).

APPENDIX E — TEXAS HEALTH CARE LIABILITY STATUTE

TEXAS CIVIL PRACTICE AND REMEDIES CODE
TITLE 4. LIABILITY IN TORT
CHAPTER 88. HEALTH CARE LIABILITY

§ 88.001. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

Appendix E

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under Chapter 843, Insurance Code.

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

Appendix E

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

§ 88.002. Application

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

§ 88.003. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with or otherwise complies with the utilization review requirements of Article 21.58A, Insurance Code, or Chapter 843, Insurance Code, unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsections (c) and (d).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under Subsection (c) as requested by a health insurance carrier, health maintenance

organization, or managed care entity must be performed in accordance with Article 21.58C, Insurance Code. The health insurance carrier, health maintenance organization, or managed care entity requesting the review must agree to comply with Subdivisions (2), (3), and (4), Section 6A, Article 21.58A, Insurance Code.

(e) Subject to Subsection (f), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(f) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading

was not made in good faith, in which case the court may enter an order pursuant to Subsection (e).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(h) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

Supreme Court, U.S.
FILED
FEB 26 2004
OFFICE OF THE CLERK

(25)

No. 02-1845

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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REPLY BRIEF FOR PETITIONER AETNA HEALTH INC.

This Court granted review to examine the Fifth Circuit's holding that a challenge to Aetna's "refus[al] to cover"—*i.e.*, pay for—a particular medication is not completely preempted by ERISA because that challenge was artfully framed as a "tort" claim for "damages" rather than an ERISA "contract" claim for "benefits." Aetna Pet. App. 2a, 16a. We restate the Fifth Circuit's holding because respondents evidently have no desire to defend the decision below on its own terms. Instead, respondents and their *amici* advance several theories designed—covertly or overtly—to persuade this Court to modify or abandon *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny. Those theories—some of which are advanced for the first time in this Court—no more support the judgment below than did the Fifth Circuit's discredited, and largely abandoned, reasoning.

Davila and his *amici* now defend the outcome reached by the Fifth Circuit based on four premises, each of which is faulty legally or factually—or both. *First*, they repeatedly assert that Aetna provided "medical treatment" to Davila or that Aetna engaged in "medical malpractice," when in fact and law Aetna's role was limited to making a coverage determination under the ERISA plan. *Second*, they contend that Davila's state-law tort claim is not within the scope of ERISA § 502(a), 29 U.S.C. § 1132(a), even though he could have challenged Aetna's decision under ERISA but chose not to do so. *Third*, they argue that Section 514 of ERISA should limit the complete-preemption analysis under Section 502, an argument that respondents clearly waived and this Court has already rejected. *Fourth*, and finally, they urge this Court to depart from two decades of settled precedent, but principles of statutory *stare decisis* preclude such a result.

ARGUMENT

I. Aetna Provides Plan Administration Services, Not Medical Treatment

Pilot Life held, and this Court has repeatedly reaffirmed, that Section 502(a) of ERISA provides the exclusive avenue for challenging allegedly improper denials of benefits under ERISA plans. *Pilot Life*, 481 U.S. at 52. Davila and his *amici* posit, however, that States traditionally have used their police powers to regulate "health care," and that such authority may be invoked to regulate health insurers' *coverage* decisions because such decisions, as a practical matter, "control" medical treatment or care.[1] Davila's attempt to label his state-law claim one for alleged "medical malpractice," however, cannot paper over the fundamental divide between coverage decisions and treatment.

Whatever power States retain to regulate "health care" in the abstract, Congress clearly intended ERISA to regulate the health *benefits* at issue here. That eligibility for such benefits may turn, in part, on medical criteria does not change the analysis: any welfare plan that provides *health* insurance necessarily uses medical criteria to delimit the scope of coverage.[2] Here, because Davila incontrovertibly challenges the propriety of Aetna's benefit determination—a coverage decision, whether or not it was based on any medical criteria—his state-law claim is completely preempted under *Pilot Life*.

1. As our opening brief demonstrated, Aetna's role under the Monitronics Plan is to make "[d]eterminations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this Certificate." J.A. 78 (boldface omitted). The Plan also explains that it "applies to coverage only and does not restrict a Member's ability to receive health care services that are not, or might not be, Covered Benefits." *Id.* at 40, 108 (boldface and capitalization omitted). And the Plan makes clear that "[i]f the Member's [physician] performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member's responsibility." *Id.* at 46 (boldface omitted).[3] These provisions refute Davila's repeated claims that Aetna's role is to provide medical *treatment*. Tellingly, the Plan itself is *nowhere* addressed in the hundreds of pages of briefs submitted by Davila and his *amici*.

Even if the Monitronics Plan did not make this point so clearly, Aetna could not make medical "treatment" decisions as a matter of law. Insurers (including Aetna) are not licensed by Texas or any other State to practice medicine. In-

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[1] *E.g.*, Resp. Br. 11 ("These are two medical-malpractice actions"), 28 ("the claim is one for defective medical care"), 65 ("the state law substantively regulates medical decision-making").

[2] "Medical necessity" plan terms also incorporate criteria *other* than medical factors. Aetna Br. 5-6; J.A. 54-55.

[3] The Plan also states, unambiguously, that "Participating Providers [*i.e.*, physicians] are not agents or employees of [Aetna]" and that they "are *solely* responsible for any health services rendered to their Member patients." J.A. 31 (emphasis added; boldface omitted). Davila contends, based on contracts *not* in the record, that Aetna requires its participating physicians to "comply" with its "medical-necessity decisions" (Resp. Br. 3 n.3), and thus legally prevents doctors from making independent treatment decisions. But the cited contracts establish only that physicians must "comply" with Aetna's "participation criteria" and "policies"—matters such as precertification requirements, confidentiality of medical records, or electronic submission of referrals. *E.g.*, Resp. Br. App. 19a. And other provisions of the same contracts—omitted from Davila's appendix—make clear that providers may freely offer members services not covered by Aetna, so long as the lack of coverage is clear to the patient. App., *infra*, 3a-4a.

deed, under the federal HMO Act, States cannot impede the formation of HMOs by requiring that licensed physicians have any particular role in the formation or management of an HMO. *See* 42 U.S.C. § 300e-10(a). Nor can Aetna or any other insurer prescribe any medications: prescriptions can be written only by a licensed physician. 21 U.S.C. § 353(b). Here, contrary to the overheated rhetoric of Davila's *amici* (*e.g.*, CCHCC Br. 6; AMA Br. 11), Aetna did not prescribe Naprosyn for Davila's condition. It was entirely up to Davila's physician—Dr. Lopez—whether to prescribe Vioxx (out of plan, if necessary), Naprosyn, or any other non-steroidal anti-inflammatory drug (NSAID) covered under the Monitronics Plan.[4] The decision to prescribe Naprosyn in particular was undoubtedly a "treatment" decision, but it clearly was one that was made by Dr. Lopez, not Aetna.[5]

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[4] Under the formulary, Davila could have obtained Vioxx coverage by showing intolerance, allergy, or contraindication to, or unsatisfactory results with, *any two* generic NSAIDs, some of which are considerably more expensive than naproxen (the generic name for the brand name Naprosyn) but nonetheless are covered without precertification. *See* Aetna Br. App. 29a.

[5] Citing the allegations of his complaint, Davila now suggests that Aetna somehow prevented him from obtaining Vioxx on his own, since "he could not even get his pharmacy to fill [Dr. Lopez's] prescription [for Vioxx]." Resp. Br. 6. But even the complaint does not assert that Aetna prevented Davila from obtaining Vioxx out of plan; the complaint alleges instead that "[w]hen [Davila] tried to fill the [Vioxx] prescription, . . . he was informed that his insurer . . . would not fill it." Aetna Pet. App. 67a. In other words, Aetna declined to *pay for* Vioxx. Davila remained free to have the Vioxx prescription filled at his own expense, following which he (or his physician, as his representative or assignee) could have pressed his claim to coverage by filing an internal appeal, seeking IRO review, or bringing an action for reimbursement under ERISA. Nothing in the record—or in common sense or experience—suggests that the *pharmacist* would not "fill" (*i.e.*, dispense) a valid prescription provided that Davila agreed to pay for it by means other than his ERISA-governed health plan.

The *amici* States now assert that "HMOs' medical necessity determinations dictate treatment through the 'utilization review' process." States' Br. 8. Not surprisingly, however, several of the same States have long recognized in formal opinions that this is simply not true. *See, e.g.*, 1999 Ohio Op. Att'y Gen. 265, 1999 WL 692623, at *4 (an "adverse determination" by an HMO "does not mean that the physician is precluded from providing the service or that the patient is precluded from obtaining the service from another source or through other means"); 1990 Kan. Op. Att'y Gen. No. 90-130, 1990 WL 547153, at *3 ("Care is not being administered or withheld by the reviewing person. . . . An insured who is denied benefits by utilization review, on the grounds that the treatment sought is not 'medically necessary' . . . , is not prevented from obtaining medical care"); *accord Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999). *See generally* J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 441-45 (1998).[6]

Similarly, although the American Medical Association makes the remarkable—and demonstrably false—assertion

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[6] Insurance coverage creates an incentive for an insured to avail himself of covered services even when they are unnecessary; utilization review allows plans to mitigate this incentive while still covering a wide variety of treatments. *See* Aetna Br. 5. Vioxx has been found to be particularly susceptible to this moral-hazard incentive. *See, e.g.*, Jalpa A. Doshi et al., *The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare*, HEALTH AFFAIRS Web Exclusive, Feb. 18, 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.94v1.pdf, at W4-102 ("[I]rrespective of the [gastrointestinal] risk, people with the most generous prescription plans in 2000 were more likely to use COX-2 inhibitors [such as Vioxx]").

that Davila did not "receive[] the course of treatment prescribed by his . . . treating physician" (AMA Br. 20), the AMA's own Code of Ethics specifically addresses the situation presented in this case, and it makes clear that the choice of medication is ultimately the patient's (in consultation with his physician), not the insurer's:

> If physicians *exhaust all avenues to secure a formulary exception* for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial drug to the patient, *so that the patient can consider whether to obtain the medication out-of-plan*. Under circumstances in which the health care program will not subsidize the drug, *physicians should help patients by identifying alternative forms of financial assistance*, such as those available through pharmaceutical companies' assistance programs.

Am. Med. Ass'n, *Code of Ethics* § E-8.135(6) (2002) (emphases added). And, according to the AMA's own Code of Ethics, doctors may recommend a covered medication only if it is just as efficacious as any non-covered medication. *See id.* § E-8.135(2); *see also* AMA Br. 9 (patients are protected by physician self-regulation). If physicians disagree with denials of coverage, they may provide the recommended care or services and pursue the ERISA beneficiaries' rights to payment themselves, pursuant to the assignment of benefits taken at the outset of providing care. *See, e.g., Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 926-27 (7th Cir. 1993).

2. The formulary exclusion of coverage for Vioxx under circumstances like Davila's does not constitute "medical treatment." Davila elected to enroll in an employer-sponsored managed care plan whose prescription coverage was subject to formulary requirements. Plainly, this Court's cases would not allow Davila to sue Aetna in state court for harm resulting from a denial of Vioxx (however strongly his

doctor recommended it) if the Plan provided that Vioxx is *never* a covered benefit. The *conditional* inclusion of Vioxx in the Plan's formulary does not alter either the relevant legal analysis or the conclusion.

Nothing in ERISA requires employers to establish employee benefits plans, or to provide any particular benefits if they do choose to have such a plan. Rather, employers have great leeway to design welfare plans as they see fit. *See Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1970, 1971 (2003); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). And once an employer chooses to provide a particular benefit under a welfare plan, *all* claims of improper denial of that benefit must be brought under ERISA. *Pilot Life*, 481 U.S. at 52. As this Court has emphasized repeatedly, ERISA's policy is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002). The AMA's suggestion that Aetna should be held liable for the formulary's limitations on *coverage* for Vioxx would allow state tort law retroactively to undo Davila's and his employer's coverage decision and to rewrite his insurance into a more expansive, and expensive, plan that neither of them selected or paid for.

By conflating the structuring of benefits with the provision of treatment, Davila and his *amici* are asking this Court to take an even larger step than the one rejected last Term in *Nord*. There, as here, eligibility for benefits under an ERISA welfare plan turned on assessing medical criteria. The unanimous opinion in *Nord* rejected the notion that ERISA plan administrators must give "more weight" to the opinion of a treating physician: benefits administration, the Court held, involves interpretation of the plan, which is not subject to reasonableness review under *medical* standards. 123 S. Ct.

at 1972 & n.4. The argument advanced by Davila and the AMA here would effectively require the administrator to give *conclusive* weight to the opinion of a treating physician and to pay for anything he recommends—or face the prospect of potentially unlimited tort damages in state court for breaching a purported state "duty of care." If ERISA does not permit a rule that grants special weight to a treating physician's judgment even in a federal suit for the benefits in question, it is difficult to see how Davila's bid for a supplemental state-court remedy to enforce that same professional judgment can be squared with ERISA.

3. To sow confusion where there is none, Davila and his *amici* recite this Court's reference in *Pegram* to a "puzzling issue of preemption" that justified reluctance to infer an ERISA case of action in that case. Resp. Br. 28 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000)) (internal quotation marks omitted). But however "puzzling" the issue might be in the context of the "mixed" decisions made by a physician owner of a group-model HMO (or a staff-model HMO, where treating physicians, like the defendant in *Pegram*, also make both coverage and treatment decisions), the issue is entirely straightforward where, as here, coverage and treatment are clearly separated. Davila offers no response to this distinction other than the question-begging assertion that HMOs "should not be permitted to avoid malpractice liability" by adopting this structure. Resp. Br. 36. But by engaging only in benefits administration—which ERISA regulates exclusively, leaving no room for additional state-law medical standards—Aetna has never entered the sphere of traditional *medical* practice that might justify subjecting it to state-law malpractice liability.[7] That sphere is left to physicians.

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[7] As both Davila and the Texas Attorney General state, the THCLA on its face applies even when the HMO provides no medical treatment, if the plaintiff shows that the HMO's coverage decision had some effect on the care ultimately provided by the physician. *See* TEX. CIV. PRAC. & REM. CODE § 88.001(5).

4. Davila's erroneous assertion that he is challenging health care "treatment" decisions—purportedly an area of "traditional" state regulation—forms the principal basis for his attempt to save his THCLA claims from preemption. *See, e.g.*, Resp. Br. 17. But Davila himself refutes his own contention by conceding that the THCLA is not "traditional" regulation of medicine at all, since it was enacted to supplement *and expand* "traditional malpractice law." Resp. Br. 4 ("Texas concluded that traditional malpractice law . . . accorded little real protection").

Moreover, even if the THCLA could be viewed as part of the States' "traditional" regulation of medicine, Davila still could not avoid *Pilot Life* and its progeny. States "traditionally" engaged in numerous forms of regulation that now are clearly barred by ERISA, including—until *Pilot Life*—punishing certain coverage decisions directly through the tort of "bad faith" or through punitive damage awards. ERISA's language, and this Court's decisions in *Pilot Life* and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), make clear that those state efforts are now completely pre-empted. As this Court has noted, "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997); *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) (domestic relations); *Boggs v. Boggs*, 520 U.S. 833, 849-50, 852 (1997) (same). In particular, it has long been clear to this Court that, notwithstanding any general presumptions against preemption, "the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrants pre-emption." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (internal quotation marks and alterations omitted).

II. Davila's THCLA Claim Falls Within The Scope Of Section 502(a)

Stripped of the litigation-driven fiction that Aetna provides medical treatment to HMO participants, Davila's claim amounts to nothing more than the contention that Aetna erroneously declined to pay for Vioxx. That is nothing other than an ERISA claim. Indeed, Davila concedes that he could have invoked ERISA remedies when Aetna refused to pay. Resp. Br. 13. That concession should be dispositive of this case.

1. Davila's THCLA claim attacks Aetna's interpretation of the plan to deny coverage, demanding punitive and compensatory damages for Aetna's alleged failure to comply with a state-law standard of "ordinary care." Contrary to Davila's contention (*e.g.*, Resp. Br. 26) that the THCLA creates a duty wholly independent of those created by the ERISA plan and does not require plan interpretation, the THCLA cause of action expressly *incorporates* the scope of coverage mandated by the plan document. TEX. CIV. PRAC. & REM. CODE § 88.002(d).[8] If an HMO denies benefits that are "not covered by the health care plan," it is not liable under the THCLA; conversely, if it denies benefits that *are* covered under the plan, it may be liable under the THCLA. *Id.*[9]

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[8] Indeed, the Attorney General of Texas admits as much, *see* States' Br. 14-15 ("[T]he plain text of the THCLA . . . establish[es] that the provision will not be read to impose an obligation that is not covered by the agreed health plan"), thus negating his own assertion that the THCLA "imposes liability for failure to follow professional standards of ordinary care, not for failure to fulfill the benefit-plan agreement," *id.* at 14.

[9] If the HMO promptly approves benefits, covered or not, it cannot be held liable under the THCLA. TEX. CIV. PRAC. & REM. CODE § 88.002(c)(2).

Thus, far from adding a substantive plan term that could permissibly be enforced *under ERISA*, *see, e.g.*, *Rush Prudential*, 536 U.S. at 379-80; *id.* at 399 (Thomas, J., dissenting); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 376-77 (1999), the THCLA attempts to impose additional liability on a subset of HMOs for failing to fulfill the very same duty that ERISA imposes—to pay benefits in accordance with plan terms. Davila and his *amici* therefore are entirely incorrect to assert (*e.g.*, Resp. Br. 20; Cmty. Rights Counsel Br. 19) that the THCLA claim does not involve determining whether coverage was correctly denied under the plan. Such a determination is an essential predicate to liability under the Texas law. *See also* U.S. Br. 14. For that reason, it is impossible to avoid the conclusion that the THCLA is precisely the type of supplemental enforcement mechanism that is precluded by Section 502(a)'s exclusive remedial scheme.

2. The LMRA cases that Davila cites as authoritative (Resp. Br. 25, 27) in fact make clear that the THCLA claim is completely preempted by Section 502(a). The THCLA claim turns on interpretation of the plan document, because it makes the denial of benefits *covered by the plan* grounds for award of a supplemental state-law remedy. In the analogous LMRA context, this Court has clearly held that if a state-law claim requires interpretation of the collective bargaining agreement, it is completely preempted. *See IBEW v. Hechler*, 481 U.S. 851, 862 (1987); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 214-15, 219-220 (1985).[10]

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[10] Davila does not cite or discuss *Allis-Chalmers* or *Hechler*, which are acknowledged as controlling in the LMRA-preemption cases he *does* cite. *E.g.*, *Caterpillar Inc. v. Williams*, 482 U.S. 386, 394-95 (1987). The consistent rule of this line of cases is this: State-law claims are completely preempted if they involve interpretation of the federally covered contract, *i.e.*, the collective bargaining agreement or ERISA plan. *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 407-08 & n.7 (1988); *Caterpillar*,

3. Davila asserts that his complaint cannot be recharacterized as alleging a Section 502(a) claim because he forwent the Vioxx and, thus, cannot now seek reimbursement for it. *E.g.*, Resp. Br. 22, 28. The twin holdings of *Pilot Life* and *Metropolitan Life*—that Congress crafted Section 502(a) to be exclusive and to federalize any state-law claim that disrupts that exclusivity—would be utterly undone by accepting Davila's view that he can obtain state-law remedies merely by waiting until ERISA remedies can no longer help him. *Cf. Republic Steel Corp. v. Maddox*, 379 U.S. 650, 653 (1965) ("A . . . rule which would permit an individual employee to completely sidestep available grievance procedures in favor of a lawsuit has little to commend it").

Davila plainly had a remedy under Section 502(a)—a suit to enforce his rights under the Monitronics Plan after exhausting his internal appeal rights. He attempts to avoid ERISA preemption by arguing that because he cannot *now* sue (as he no longer seeks the Vioxx and incurred no expense that can be reimbursed), his state-law claim is viable and cannot be removed. Resp. Br. 22. Davila's argument—that Congress carefully delimited the remedies available under ERISA, only to allow plaintiffs to overcome those limitations at will by waiving their federal remedies—is contrary to both common sense and settled principles of federal jurisdiction. A claim ostensibly pleaded under state law but falling within

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482 U.S. at 395; *Hechler*, 481 U.S. at 862; *Allis-Chalmers*, 471 U.S. at 218. Davila has *no* relationship with Aetna outside the confines of his ERISA plan (whereas he *does* have such a relationship with his treating physician), and his THCLA claim expressly turns on interpretation of that plan, *see supra* pp. 10-11. *Compare Caterpillar*, 482 U.S. at 396-97 (claim depended entirely on a contract *other than* the collective bargaining agreement). Under the LMRA cases, therefore, Davila's claim plainly is completely preempted—whether pleaded in tort or contract. *See Allis-Chalmers*, 471 U.S. at 213-15.

the exclusive scope of Section 502(a) is one arising under federal law. *Metropolitan Life*, 481 U.S. at 66, 67. Such a claim, like any other within federal question jurisdiction, may be brought in or removed to federal court even if it does *not* state a *viable* claim on the merits. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 95-96 (1998); *Bell v. Hood*, 327 U.S. 678, 682 (1945); *see also Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 700-01 (7th Cir. 1991) (Easterbrook, J.). For this reason, this Court has expressly *rejected*, as "squarely contrary" to precedent, the argument that complete preemption is unavailable "unless the federal cause of action relied upon provides the plaintiff with a remedy." *Caterpillar Inc. v. Williams*, 482 U.S. 386, 391 n.4 (1987). *Metropolitan Life*—the sole cited source for Davila's proposed rule—holds that within Section 502(a)'s scope, only federal claims are possible (*see* 481 U.S. at 64, 66); it does *not* hold that only if federal relief is possible does a claim fall within Section 502(a)'s scope.

This Court sent no contrary signal in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), on which Davila and his *amici* rely for the proposition that complete preemption should be construed narrowly. Resp. Br. 20-24. *Franchise Tax Board*, which antedated both *Metropolitan Life* and *Caterpillar*, is inapposite because it specifically left open the question presented here—*i.e.*, whether plan beneficiaries' state-law claims are federalized if they fall within the scope of Section 502(a)—and that question was later expressly *answered* in *Metropolitan Life*. *See* 481 U.S. at 64. The Franchise Tax Board's collection action did not fall within the scope of Section 502(a) because *at no time* did that provision give it a remedy: state agencies—unlike plan beneficiaries—are not proper plaintiffs under Section 502(a). 463 U.S. at 25-27. Taylor, by contrast, was a plan beneficiary who could have challenged plan-administration decisions under ERISA but sought state-law damages instead, placing his complaint—like Davila's—

within the scope of Section 502(a). *See* 481 U.S. at 61. That suffices to confer removal jurisdiction: it has been clear since the first complete-preemption case that there is no additional requirement that the plaintiff state a *viable* federal claim. *See Caterpillar*, 482 U.S. at 391 n.4.

4. The assertion that there can be no preemption in this area because Congress has failed to create a remedial scheme, or that displacing state law would leave behind a "regulatory vacuum" (Resp. Br. 41), is simply inaccurate. Congress *has*, in fact, created a thoroughly detailed remedial scheme, which the Secretary of Labor has amplified by imposing specific and detailed requirements on the internal appeals process that, in most cases, should obviate the need for litigation at all. 29 C.F.R. § 2560.503-1. When plaintiffs properly resort to litigation, remedies are available—not *every* remedy a plaintiff might desire, but as this Court has held, ERISA "resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993). ERISA favors prospective remediation in the hope that judicial review will prove unnecessary; where retrospective litigation is necessary, however, *all* members of this Court have *repeatedly* agreed that Congress refused to permit recovery of the punitive damages Davila seeks. *See* Aetna Br. 20-21.

III. The Section 514 Principles On Which Davila Relies Are Inapposite

Davila and his *amici* mount a further assault on *Pilot Life* and its progeny by attempting, first, to import into the Section 502(a) preemption analysis the distinct requirements of "relates to" preemption under ERISA § 514, 29 U.S.C. § 1144, and then to invoke exceptions to the latter species of preemption. Most of those arguments are waived because Davila never raised them before his brief on the merits in this Court. All are, in any event, meritless.

1. Davila contends that the "insurance savings clause" and the federal-law exception found in ERISA's general defensive-preemption provision, Section 514, must also be read to qualify the preemptive effect of any other provision of ERISA, and in particular that those provisions should limit Section 502(a)'s preemptive force. With respect to the federal-law exception, Davila attempts to invoke the McCarran-Ferguson Act, 15 U.S.C. § 1012, which has no substantive effect other than to create a *presumption* that federal statutes do not displace state insurance regulation—a presumption rebutted by ERISA, which delineates in Section 514(b) which state insurance laws are saved and which are not.[11]

a. At no point in this litigation—in the district court, in the court of appeals, or at the certiorari stage—has Davila previously asserted that Section 514's insurance saving clause or its federal-law exception applies to save his THCLA claims for complete preemption. Davila's merits brief marks the first appearance of this contention.[12] Indeed, in resisting certiorari, Davila actually underscored the distinction between Section 502 and Section 514, noting that "section 502(a) complete preemption is very different from section 514's 'relates to' preemption." Br. in Opp. 1 n.1. Because Davila never suggested to this Court until now that the Fifth Circuit's judgment could be sustained based on Section 514's insurance saving clause or federal-law exception, those contentions are waived. *See* SUP. CT. R. 15.2; *Okla.*

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[11] Indeed, Davila's attempt to import the McCarran-Ferguson Act into ERISA would read Section 514(b)(2)(B)'s "deemer clause" entirely out of the statute.

[12] Respondents halfheartedly claim to have raised the savings clause in the court of appeals (Resp. Br. 51 n.25), but the sources they cite do not bear out that assertion: a Rule 28(j) letter whose discussion of *Rush Prudential* dealt exclusively with Section 502(a), and a footnote referring to the grant of certiorari.

City v. Tuttle, 471 U.S. 808, 815-16 (1985); *see also, e.g., S. Cent. Bell Tel. Co. v. Alabama*, 526 U.S. 160, 171 (1999).

b. It is a bit hard to see how Davila can argue that the THCLA is directed at the "business of insurance," given his primary contention that the Act addresses "medical malpractice." But in any event, this Court has already considered and rejected the notion that Section 514's insurance savings clause negates the complete preemption doctrine in the insurance context. *Precisely* this argument was made to this Court in *Pilot Life*. *See* Br. for Respondent, *Pilot Life Ins. Co. v. Dedeaux*, No. 85-1043, at 6-7, 15-17 (Oct. 31, 1986). This Court rejected that argument, stating that the state tort action was not saved in part *because* it conflicted with Section 502(a). *Pilot Life*, 481 U.S. at 52, 57. Indeed, the Court explained that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not the business of "insurance" that Congress intended to preserve for State regulation. *Id.* at 57; *see also Rush Prudential*, 536 U.S. at 377 (noting that *Pilot Life* "anticipated" that the savings clause "los[es] out" to "the congressional policies of exclusively federal remedies").

In sum, *Pilot Life* teaches that the exclusivity of Section 502's remedies is so essential to the statutory scheme that it must inform whether specific conduct is the business of "insurance" that States may regulate. Put another way, laws that attempt to supplement the exclusive remedies that Congress provided in Section 502 do not address the business of "insurance"; they address the business of ERISA. In resurrecting this waived savings-clause argument seventeen years after its initial rejection, Davila signals yet again the weakness of his arguments for affirming the Fifth Circuit's judgment.

2. Davila also asserts that the "relate to" provision of Section 514(a), the defensive-preemption provision, is a component of the Section 502(a) analysis. This Court has never even hinted that the complete preemption doctrine incorporates *defensive* preemption principles as an additional component of the analysis,[13] and the courts of appeals have largely rejected such an approach as contrary to both the history of Section 502(a) and settled precedent.[14]

First, the complete preemption doctrine under ERISA rests on Congress's express incorporation of the analogous doctrine under the LMRA. That statute has no preemption clause, but as this Court unanimously concluded in *Metropolitan Life*, Congress unambiguously directed that the rights of action under ERISA § 502(a) be given the same exclusive sweep as the right of action under LMRA § 301. *See also, e.g., Tovey v. Prudential Ins. Co. of Am.*, 42 F. Supp. 2d 919, 923 (W.D. Mo. 1999) (citing cases). Davila's contention that the existence of a defensive preemption clause narrows the reach of complete preemption therefore is unavailing, as complete preemption is premised on supplemental state remedies' conflict with the exclusivity of Section 502(a). *See, e.g., Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 352 (2001); Aetna Br. 39 & n.21.

Second, as Davila himself emphasizes (Resp. Br. 20-22, 24), Section 514 defensive preemption creates a *defense* that

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[13] To the contrary: *Ingersoll-Rand* noted that the Texas cause of action would be completely preempted by Section 502(a) "[e]ven if there were no express pre-emption in this case." 498 U.S. at 142.

[14] The en banc Fifth Circuit recently concluded unanimously that this Court's cases compel the conclusion that defensive preemption is not a prerequisite to complete preemption. *Arana v. Ochsner Health Plan*, 338 F.3d 433, 439-40 (5th Cir. 2003) (en banc), *cert. denied*, 124 S. Ct. 1044 (2004); *accord Ervast v. Flexible Prods. Co.*, 346 F.3d 1007, 1014 (11th Cir. 2003); *see also, e.g., Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 171-72 (3d Cir. 1997). *But see Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 953 (9th Cir. 1998).

does not give rise to federal jurisdiction. Section 502(a) complete preemption, by contrast, is *not* just a defense, but a federalizing force that creates a federal cause of action *despite* the plaintiff's attempt to avoid pleading one. Thus, a federal court to which a completely preempted claim is removed must first satisfy itself of removal jurisdiction by deciding whether the claim falls within the scope of Section 502(a). *See, e.g.*, *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 163, 165 (1997) ("The propriety of removal . . . depends on whether the case originally *could* have been filed in federal court" (emphasis added)). If it does, the plaintiff's claim is recharacterized as necessarily federal and any contrary aspects of the putative state-law claim are displaced, with no further need to assert the defense created by Section 514(a), whose sole effect is to displace state laws. For those reasons, it is implausible to assert that the Section 514's "relate to" analysis is somehow *antecedent* to the Section 502(a) question, when standard removal procedure dictates precisely the opposite.

IV. The Court Should Decline The Invitation To Overrule The *Pilot Life* Line Of Cases

This Court has already given plenary consideration to the issues raised in this case on multiple occasions. As we show above, the particular benefits at issue here and in *Pilot Life* and *Metropolitan Life* are not materially distinguishable; ERISA subjects welfare benefit plans to the same uniform federal regulatory and remedial regime. *See* ERISA §§ 3(1), 3(3), 4, 29 U.S.C. §§ 1002(1), 1002(3), 1003.

Relying on these holdings, employers have structured welfare benefit plans, and managed care companies and other service providers have priced their services, all in the expectation that they will be subject to ERISA's remedial scheme, with its focus on internal dispute resolution and prospective relief rather than courtroom litigation and exemplary damages. *See, e.g.*, Aetna Br. 2-3, 43; AAHP-HIAA Br. 25-26;

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10-11 (1987) (unpredictable litigation burdens may well cause "employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them").[15] The reliance interest thus created in one of the largest sectors of the economy is reason in and of itself to continue to adhere to *Pilot Life* so long as the statutory text interpreted in that case remains unchanged. *See, e.g.*, *Allied-Bruce Terminix, Inc. v. Dobson*, 513 U.S. 265, 272 (1995); *id.* at 283-84 (O'Connor, J., concurring). In stark contrast to these tangible interests, the "settled expectations" marshaled by Davila on the other side of the scale (Resp. Br. 66-67)—*i.e.*, the public's interest in "federalism," which is to say in States' supposed ability to override long-settled federal law in the name of "protect[ing] . . . safety"—smack more of sloganeering.

Davila insists that this Court retains unfettered discretion to abandon *Pilot Life* and the cases that have built on it, on the theory that what this Court has "judicially implied" it may freely recant. But that notion utterly discounts the basis of *Pilot Life* and *Metropolitan Life*. In both cases (as in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985), before them), this Court held that *Congress* had clearly made the choices that the Court must implement: to subject welfare benefits to the ERISA remedial scheme; to

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[15] A departure from that regime would undoubtedly increase the already high cost of employer-provided health insurance. *See generally* ECONOMIC REPORT OF THE PRESIDENT ch. 11 (2004). Though Davila and his *amici* quibble over percentages, it is uncontested that even a *fractional* increase in health care costs would add tens of billions of dollars to the nation's health care bill. *See, e.g.*, *Health-Care Tab Hits $1.7 Trillion*, WALL ST. J., Feb. 12, 2004, at D2. The precise dollar figure is, of course, in dispute, *compare* U.S. Chamber Br. 25-26 *with* Resp. Br. at 67—but that dispute serves only to reinforce the propriety of leaving this sort of classically legislative judgment to the political process.

make that remedial scheme thorough but to exclude certain remedies from its scope; and to preempt any state-law right of action that disrupts that exclusivity. *Metropolitan Life*, 481 U.S. at 64-65 (citing *Pilot Life*, 481 U.S. at 54).

If Congress disagrees with this Court's construction of ERISA, or is persuaded that additional remedies should be available to plan participants and beneficiaries, it remains free to legislate in this area. Indeed, Congress *has* added additional remedies to ERISA. *E.g.*, Pension Annuitants Protection Act of 1994, Pub. L. No. 103-401, 108 Stat. 4172. Congress also has considered—but failed to enact—other changes in benefits law, including expanding available remedies, a number of times in recent years. *E.g.*, Aetna Br. 42 n.23. Undaunted, the legislative proponents of those unsuccessful measures now ask this Court to embrace remedies that the Congress as a whole has declined to enact. *See* Br. for Sen. Kennedy et al. 25 (asserting that it is "easier" for this Court to change *Pilot Life* judicially than for Congress to do it legislatively). But those pleas provide no legal basis for eschewing this Court's traditional adherence to statutory *stare decisis*. Because there is no substantial basis for this Court to revisit *Pilot Life*, Davila's state-law claims must fail.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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February 26, 2004

APPENDIX

THIS AGREEMENT CONTAINS
AN ARBITRATION PROVISION

PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

* * * *

3.0 COMPENSATION

3.1 Payment. Company's compensation methodologies are designed to promote Member access to quality care. Company shall, or when it is not the applicable Payor shall notify each Payor to, pay Physician for Primary Care Services rendered to Members in accordance with: (a) the Physician Compensation Model as described in the Compensation Schedule; (b) any other applicable Attachment; or (c) the fee schedule then in effect as applicable to such Members' Plans; any of which may be modified from time to time. Physician's compensation for non-capitated Covered Services rendered to Members shall be (A) the lower of (i) the compensation arrangement in effect hereunder, or (ii) Physician's reasonable and customary billed charge, (B) minus any applicable Copayments, Coinsurance or Deductibles. Payments for non-capitated Covered Services are subject to any and all valid and applicable laws related to claims payment. Except for capitated services, in the event Company fails to pay a Clean Claim within forty-five (45) days of submission, upon written notice from Physician of such event, Company shall pay a contracted penalty of **[VARIABLE: one to twenty]** percent **[VARIABLE: (1-20%)]** per month simple interest on the eligible, unpaid portion of such Clean Claim(s), beginning on the 46th day after submission of that Clean Claim through the date on which payment is made. Physician shall not be entitled to billed charges for any Clean Claim. Physician shall not be entitled to receive either billed charges or the contracted penalty for claims under self-funded Plans. Physician shall notify Com-

pany of any overpayments or payments made in error within ten (10) business days of becoming aware thereof, and shall return or arrange the return of any such overpayments or payments made in error to Company, or to Payor or Member, as applicable. Physician shall hold Company, Affiliates, Sponsors, Members and Payors harmless against any and all claims by covering providers related to or arising out of payment for Covered Services rendered to Members. Notwithstanding anything to the contrary in this Agreement, to the extent Company has communicated approval of payment for Covered Services, Company shall pay for such Covered Services absent: (a) fraud; (b) materially changed condition of the Member's health status (meaning a material change in the Member health status between the time that Company communicates approval of payment for Covered Services and the time that those Covered Services are provided, such that the Covered Services for which Company has communicated approval of payment are not medically necessary due solely to the material change in the Member's health); or (c) the individual receiving the services was not a Member at the time such care is delivered. Notwithstanding anything in this Agreement to the contrary, during such time as Physician is a member of a Group, Physician seeks to seek compensation solely from Group for those Covered Services provided to Members and for which Group is compensated by Company on behalf of Physician, and Physician shall in no event bill Company, its Affiliates, Payors or Members for any such Covered Services (except for the collection of Copayments, Coinsurance, Deductibles in accordance with Section 3.2). When Company is not the Payor, Company shall have no obligation to pay Physician in the event that the Payor or Member fails to pay Physician. Company agrees that it shall not offer Physician compensation arrangements that: provide additional compensation for not exceeding certain budgets, impose a penalty for incurring expenses that are medically necessary, make additional compensation available

for limiting medically necessary services or will be affected by the actual (as opposed to projected) costs of services or the actual rate of utilization of services during the contract year. This will not prohibit Company from providing additional compensation to Physician for providing preventive care or in the event the actual costs or utilization of services were more than the projected costs or utilization.

3.2 Billing of Members. Under certain Plans, members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Physician shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Such amounts collected must be based only on the compensation herein. Copayments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, Physician may bill Members only in the circumstances described below:

3.2.1 If the applicable Payor is not an HMO, Physician may bill a Member for Primary Care Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Physician shall have first exhausted all reasonable efforts to obtain payment from the Payor; and (b) Physician shall not institute or maintain any collection activities against a Member to collect any sums that are owed by a Payor to Physician unless Physician provides prior notice to Company of Physician's intent to institute such activities.

3.2.2 Services that are not Covered Services may be billed to Members by Physician only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services

may not be Covered Services; and (c) the Member agreed in writing to pay such services.

Noting in this section is intended to prohibit or restrict Physician from billing individuals who were not Members at the time that services were rendered.

3.3 Coordination of Benefits. When a Payor is the primary payor under applicable coordination of benefit principles, the Payor shall pay in accordance with this Agreement, and when a Payor is secondary under said principles, Payor's payment shall be limited as specified in the applicable Plan. If the Plan fails to specify coordination of benefits requirements, and unless prohibited by applicable law, Payor's payment shall be limited to the amount which, together with the amount paid by the primary payor following all reasonable efforts by Physician to collect same, equals the compensation due to Physician under this Agreement, or if the primary payor fails to pay, Payor's payment shall be in accordance with this Agreement. In no event shall amounts billed and retained under coordination of benefits for Covered Services exceed Physician's usual and customary billed charges for such services.

3.4 Claims Submission. Physician shall submit claims to Company or the applicable Payor for non-capitated Primary Care Services rendered to Members. Claims shall be submitted within ninety (90) days of the date of service or Physician's receipt of an explanation of benefits from a primary payor. Billings shall include detailed and descriptive medical and Member data and identifying information on HCFA 1500 forms or any subsequent form adopted for that purpose. Physician shall submit bills electronically as required by Company or the applicable Payor. Company primarily utilizes CPT for the coding and description of services. If Physician has not billed Company or the applicable Payor within the stated time frame, Physician's claim shall be deemed waived, and Physician shall not bill any other person or entity, including, but not limited to, Company, the applicable

Payor, Sponsor, or Member, for such services. Company may return to Physician any claims which are incomplete, inaccurate, or not in the proper format as required by Company. Statements made in any claim or related documentation submitted by or on behalf of Physician shall be considered statements made by Physician, regardless of whether such statements are prepared by Physician's employees, agents, or representatives. Any adjustments to claims submitted by Physician must be filed with Company or the applicable payor within thirty (30) days of the submission of the original claim, or the original claim will be deemed final.

3.5 Holding Members Harmless. If the applicable Payor is an HMO, Physician hereby agrees that in no event, including, but not limited to, non-payment by the HMO, insolvency of the HMO or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than the HMO) acting on a Member's behalf for Covered Services. This provision shall not prohibit collection of Deductibles, Coinsurance, or Copayments from Members in accordance with the terms of the Member's Plan.

Physician further agrees that: (a) this provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Physician and a Member or persons acting on a Member's behalf.

Any modifications, additions or deletions to the provisions of this clause shall become effective on a date no earlier than 15 days after the Commissioner of Insurance has received written notice or such proposed changes.

* * * *

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Nos. 02-1845, 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC. AND CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state-law tort claim seeking damages for an allegedly erroneous determination of entitlement to a benefit under an ERISA-governed health benefit plan when the determination is based in part on the exercise of medical judgment?

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The Chamber of Commerce of the United States (the "Chamber") respectfully submits this brief pursuant to Supreme Court Rule 37.4 in support of Petitioners in both *Aetna Health Inc. v. Davila*, No. 02-1845 (granted Nov. 3, 2003), and *CIGNA HealthCare v. Calad*, No. 03-83 (granted Nov. 3, 2003).[1] The Chamber urges the Court to reverse the judgment of the United States Court of Appeals for the Fifth Circuit and hold that the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003, as applied in these cases, is preempted by § 502(a) of ERISA.

INTEREST OF *AMICUS CURIAE*

The Chamber is the world's largest business federation. It represents an underlying membership of more than three million businesses and organizations in every industrial sector and geographic region of the county. A principal function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. In this regard, many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans falling within the scope of ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is thus of vital importance to its members, their employees, the employees' dependents, and the Chamber.

In addition, the Chamber is concerned about the adverse effect that the imposition of myriad different and sometimes inconsistent state and federal obligations has on its members in regulated industries. The Chamber accordingly has filed numerous *amicus* briefs in this Court on the subject of federal

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity other than the Chamber has made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this *amicus* brief, and their consent letters are on file with the Clerk's Office.

preemption, including preemption under ERISA. *See, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219 (1995); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

SUMMARY OF ARGUMENT

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) ("*Pilot Life*"), this Court unanimously held that ERISA § 502(a) was intended to be the "exclusive" vehicle for challenging a determination of a "claim for benefits," and that state laws seeking to expand § 502(a)'s remedies are "completely preempted" by ERISA—that is, the complaint is deemed to raise a federal question for jurisdictional purposes and is also substantively preempted. Since *Pilot Life*, the Court has repeatedly reaffirmed these basic legal principles. *See, e.g.*, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) ("[A] suit by a beneficiary to recover benefits from a covered plan ... falls directly under § 502(a)(1)(b) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes."); *Ingersoll-Rand*, 498 U.S. at 145 ("Not only is § 502(a) the exclusive remedy for vindicating [ERISA]-protected rights, but there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek 'pension benefits.'"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (observing that complete preemption applies where "state law duplicat[es] the elements of a claim available under ERISA" and "convert[s] the remedy from an equitable one . . . into a legal one."); *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062-63 (2003) (relying on these cases to reaffirm the "complete preemption" doctrine).

In light of these long-standing principles accepted in *Pilot Life*, the Fifth Circuit plainly erred when it concluded that the THCLA is not completely preempted as applied here. Under the Texas statute, an ERISA-plan participant can seek damages for an erroneous health benefit determination when the

determination is based in part on the exercise of medical judgment. *See* Tex. Civ. Prac. & Rem. Code § 88.002. ERISA § 502(a)(1)(B), however, provides a remedy for improper benefits determinations, including determinations based on medical judgment, and the ERISA remedy does not include the legal damages that Texas law allows. *See* 29 U.S.C. § 1132(a)(1)(B). *Pilot Life* thus compels the conclusion that the THCLA is completely preempted.

There is, moreover, no persuasive justification for departing from the long-standing rule that state-law causes of action challenging alleged erroneous benefit determinations are completely preempted. In the sixteen years since the interpretation of ERISA § 502 was settled in *Pilot Life*, employers and health benefit plan sponsors have relied on this Court's preemption decisions when designing benefit plans. Indeed, virtually every health benefits plan in the country—not only those run by HMOs but also traditional fee-for-service plans—limits treatment to only "medically necessary" procedures and excludes "experimental" procedures. When including these discretionary-judgment provisions in their health plans, employers justifiably assumed that state-law challenges to a plan's administration would be preempted. Changing or abandoning that statutory precedent now would unfairly expose plan sponsors to potentially massive, retroactive financial liabilities in all 50 States.

Nothing since the enactment of ERISA or the issuance of *Pilot Life* counsels in favor of altering this Court's preemption jurisprudence and thereby undermining these justifiable reliance interests of plan sponsors in the Court's interpretation of ERISA § 502. Certainly, the mere existence of HMOs and their practice of utilization review are not new phenomena that justify a change in statutory precedent. Nor are legal remedies necessary to redress some perceived economic imbalance between HMOs—which are only a subset of employee benefit plans—and health benefit plan participants. Employers and plan sponsors, who ultimately pay for health plans, exercise

significant market power over HMOs and other managed care organizations. As a result, employers can, and do, ensure that health plans provide the benefits for which they contracted and opt out of health plans administered improperly. Numerous legal safeguards also protect against arbitrary acts by benefits administrators. For example, plan participants who believe they have been wrongly denied coverage can seek independent review under state insurance laws and/or seek injunctive relief under ERISA.

This Court should not alter these traditional preemption principles out of concern for the States' interest in regulating the practice of medicine. Doing so would substantially increase the cost of health care coverage and reduce the availability of affordable health insurance nationwide, contrary to ERISA's purposes. Benefits determinations—even those involving medical judgment—are not, moreover, medical treatment decisions, as principles of contract interpretation and Department of Labor regulations well demonstrate. States have sufficient authority to regulate the practice of medicine and the conduct of treating physicians. In addition, they can require independent review of benefit determinations by insured plans and, if they desire, mandate the provision of benefits by insured plans. What States cannot do is impose tort liability on the basis of a benefits determination. To the extent there is any doubt on this score, case law under § 301 of the Labor-Relations Management Relations Act ("LMRA")—which served as the model for § 502 of ERISA—makes clear beyond peradventure that the claims here are preempted.

ARGUMENT

I. THIS COURT'S PRIOR DECISIONS BAR STATES FROM CREATING TORT ACTIONS FOR IMPROPER BENEFITS DETERMINATIONS.

A. Numerous Cases Establish That State Law Claims Challenging Benefits Determinations—Even Ones That Involve Medical Judgment—Are Completely Preempted Under ERISA § 502(a).

It is well established that ERISA § 502(a) provides the exclusive remedy for violations of the rights and benefits guaranteed under ERISA. The Court first recognized the exclusivity of § 502(a) sixteen years ago in *Pilot Life*.

In that case, an employee sued Pilot Life Insurance for breach of contract, breach of fiduciary duty and fraud in the inducement after Pilot Life repeatedly terminated and reinstated the employee's disability benefits. In an opinion authored by Justice O'Connor, the Court unanimously concluded that state law actions challenging allegedly improper benefits determinations are completely preempted by ERISA. The Court reasoned that "[t]he conclusion that § 502(a) was intended to be exclusive" is demonstrated "by the language and structure of the civil enforcement provisions," as well as by its legislative history. *Pilot Life*, 481 U.S. at 52.

With respect to ERISA's language, the Court observed:

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54. With respect to the legislative history, the Court found that it "fully confirmed" this reading of § 502(a). *Id.* The Court noted that the Conference Report described § 502(a) as "in similar fashion" to § 301 of the LMRA, which the Court characterized as an act with "powerful pre-emptive force" that displaced "all state actions for violation of contracts between an employer and a labor organization, even when the state action purport[s] to authorize a remedy unavailable under the federal provision." *Id.* at 54-55 (internal quotations and citation omitted).

Since *Pilot Life*, this Court has repeatedly reaffirmed that § 502(a) of ERISA is the exclusive vehicle for any challenge to a benefits determination and defines exclusive remedies for claims covered by ERISA. In *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), the Court unanimously concluded that an employee could not sue under state law for an employer's failure to pay disability benefits; Congress had so completely preempted this area "that any civil complaint raising this select group of claims [within the scope of ERISA] is necessarily federal in character." *Id.* at 63-64. Similarly, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), an employee sued his employer for wrongful discharge under state law, claiming that his employer terminated him to avoid paying pension benefits. *Id.* at 136-37. The Court unanimously held that the wrongful discharge action was preempted because the underlying complaint fell within the "ambit of ERISA['s]" substantive provisions. *Id.* at 142. In *Rush Prudential v. Moran*, 536 U.S. 355, 379 (2002), although the Court found that state utilization review statutes are not preempted, it observed that state laws are "incompatible with ERISA's enforcement scheme" and preempted if they "provid[e] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA." *Id.* at 379. Most recently, in *Beneficial National Bank v. Anderson*, 123 S. Ct. 2058, 2062-63 (2003), this Court relied on *Pilot Life* and its progeny to reaffirm the "complete preemption" doctrine.

B. The Fifth Circuit's Analysis Is Erroneous.

In light of this precedent, the Fifth Circuit plainly erred in holding that the THCLA is not completely preempted by ERISA § 502. Under § 502(a)(1)(B), "a participant or beneficiary" of an employee benefits plan is entitled "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Whether the benefits determination involves some medical judgment is irrelevant to this ERISA remedy, as § 502(a)(1)(B) applies regardless of the kind of factors relied upon by the plan in making a benefits determination. *See, e.g., Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1968-71 (2003) (considering claim for disability benefits where benefits denied allegedly due to improper medical determination). Department of Labor regulations confirm that the presence of some medical judgment does not convert a benefits determination into a medical treatment decision; it remains a "benefits determination that is based in whole or in part on a medical judgment." 29 C.F.R. § 2560-503-1(h)(3)(iii).

Because this § 502(a) remedy is exclusive, the State of Texas cannot supplement or restrict the ERISA remedy. That, however, is precisely the THCLA's function. It provides plan participants a new damages remedy whenever an HMO erroneously denies coverage due to some mistake in medical judgment. *See* Tex. Civ. Prac. & Rem. Code § 88.002. As such, the THCLA is completely preempted under *Pilot Life* and its progeny.

In reaching the contrary conclusion, the Fifth Circuit committed several errors. *See Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002). As an initial matter, the Fifth Circuit all but ignored *Ingersoll-Rand*, which reaffirmed the core holding in *Pilot Life* that state law cannot provide a remedy for conduct that is covered by § 502(a). In addition, the Fifth

Circuit wrongly departed from *Pilot Life* based on an erroneous reading of this Court's decision in *Rush Prudential*.

In the Fifth Circuit's view, *Rush Prudential* held that "*Pilot Life*'s rule is a narrow one: States may not *duplicate* the causes of action listed in ERISA § 502(a)." *Roark*, 307 F.3d at 310-11 (emphasis supplied). *Pilot Life* itself, however, rejected this narrow approach to preemption, holding instead that "*all suits* brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." 481 U.S. at 56 (emphasis supplied). Indeed, the plaintiff in *Pilot Life* pursued claims such as emotional distress that did not have exactly the same elements as a § 502(a) claim. The Court nonetheless held these claims preempted, because they all arose from the same event governed by ERISA—the determination of benefit eligibility.

Far from revisiting *Pilot Life*, *Rush Prudential* confirmed that state law is preempted whenever it supplements an ERISA remedy, because state law cannot "expan[d] the potential scope of ultimate liability imposed upon employers by the ERISA scheme." *Rush Prudential*, 536 U.S. at 379. The supposedly "limiting" language from *Rush Prudential* that the Fifth Circuit cites—ERISA exclusivity applies when a state law "*duplicate*[*s*] the elements of a claim available under ERISA," *id.* (emphasis supplied)—does not signal a departure from *Pilot Life*. The Court was not there requiring an identity of every element of a state law and the § 502(a) remedy for preemption to apply. It was merely observing that, where ERISA provides a remedy for some underlying wrong, state law cannot add to that remedy. *Id.* The Fifth Circuit's effort to read more into *Rush* is untenable.

C. The Contrary Analysis Of Other Courts Of Appeals Is Also Similarly Unpersuasive.

Although not part of the Fifth Circuit's analysis, the Second Circuit has suggested that state-law actions challenging allegedly erroneous medically-based eligibility determinations are not preempted because *Pegram v. Herdrich*, 530 U.S. 211 (2000) ("*Pegram*"), "alters the framework" of ERISA preemption. *See Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003). In the Second Circuit's view, *Pegram* teaches that distinguishing between medical care and benefits administration "is no longer tenable" and "demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component." *Id.* at 102, 103. *Pegram* cannot properly be read to so alter *Pilot Life*.

Pegram concerned whether an HMO could be held liable for breach of fiduciary duty, *see* 29 U.S.C. § 1109(a), where a single physician providing medical treatment acts both as the plaintiff's treating physician and as administrator of an HMO. In that case, the physician allegedly delayed necessary treatment to maximize the HMO's financial gain, and the plaintiff suffered a serious physical injury as a result. *See Pegram*, 530 U.S. at 216-17. The Court concluded that "Congress did not intend [the physician] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." *Id.* at 231.

Pegram clearly did not alter the framework of § 502(a) preemption established by *Pilot Life* and its progeny. In *Pegram*, the plaintiff did not contend that the HMO or physician rendered an improper benefits determination, but argued only that the HMO had violated its fiduciary duty by failing "to act solely in the interest of beneficiaries." *Pegram*, 530 U.S. at 226; *see also id.* at 229 n.9. Moreover, the Court concluded only that an HMO does not act as a fiduciary under ERISA when a single

physician treats patients and administers an HMO. *Id.* at 236-37. While the Court noted that its conclusion helped avoid "a puzzling issue of preemption," the Court expressly declined to decide *any* ERISA preemption question. *Id.* at 229 n.9 (observing that Court had "no occasion to discuss the standards governing" a § 502(a)(1)(B) claim or "the interaction of such a claim with state-law causes of action"). Thus, *Pegram* cannot conceivably stand as doctrinal authority for a departure from *Pilot Life* and its progeny.

Nor is the preemption issue that concerned the Court in *Pegram* even implicated by the kind of state law causes of action saved by the Fifth Circuit below and the Second Circuit in *Cicio*. In *Pegram*, because a single physician was both the treating physician and the HMO administrator, it could be argued that the physician and his employer, the HMO, were providing medical services and should arguably be subject to state malpractice claims for alleged erroneous treatment decisions. *Pegram*, 530 U.S. at 236-37. But this argument is inapposite where the benefits plan administrator is not the treating physician at all. In these circumstances, the plan is clearly making only benefits determinations, not treatment decisions, and thus is plainly subject to the exclusive province of § 502(a) of ERISA.

D. There Has Been No "Retrenchment" From § 502 Preemption Principles.

In addition to erroneously interpreting *Pegram*, the Second Circuit suggested that this Court has "tempered" its preemption analysis and that "the criteria set forth in early cases like *Shaw* and its progeny have in effect been abandoned." *Cicio*, 321 F.3d at 99 (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring)). But the Court's reconsideration of its ERISA § 514 jurisprudence is irrelevant here: as Judge Calabresi pointed out in his dissent, *see Cicio*, 321 F.3d at 108, and as the Second Circuit inconsistently acknowledged, *id.* at 99-100, this

Court has not retrenched at all from the basic principle that § 502 preempts suits seeking relief for an erroneous benefits determination.

II. THERE IS NO PERSUASIVE JUSTIFICATION FOR ABANDONING *PILOT LIFE*.

The real issue here is thus not whether *Pilot Life* and its progeny answer the question presented, but whether the Court should abandon or revise this otherwise controlling precedent. That question must be answered by reference to the decisional principles governing *stare decisis*, and those principles counsel decisively against altering *Pilot Life* and its progeny.

A. *Stare Decisis* Principles.

This Court has repeatedly recognized that "any departure from the doctrine of *stare decisis* demands special justification." *Arizona v. Rumsey*, 467 U.S. 203, 212 (1984). Indeed, because the principle of *stare decisis* has "special force in the area of statutory interpretation," *Patterson v. McLean Credit Union*, 491 U.S. 164, 173 (1988), altering the rule of law in a case such as this one demands some additional basis for overcoming the strong "presumption of adherence" to cases interpreting statutes. *Ill. Brick Co. v. Illinois*, 431 U.S. 720, 736 (1977); *Hilton v. S.C. Pub. Rys. Comm'n*, 502 U.S. 197, 205 (1991) (*Stare decisis* is most compelling where "a pure question of statutory construction is involved."). In considering whether to revisit existing precedent, the Court considers whether "there has been reliance on the decision" such that "to disturb it now would be fraught with many injurious results." *United States v. Title Ins. & Trust Co.*, 265 U.S. 472, 486 (1924). *See also Dickerson v. United States*, 530 U.S. 428, 443 (2000) (declining to overrule *Miranda*). The Court also reviews whether the factual or legal landscape has so changed since its earlier decision as to rob it of justification or workability. *See, e.g., Burnet v. Coronado Oil & Gas Co.*, 285 U.S. 393, 412 (1932) (Brandeis, J., dissenting); *Planned Parenthood of S.E. Pa. v. Casey*, 505

U.S. 833, 854-55 (1992). Mere asserted error in a prior decision or a change in Court personnel—such that a new majority would decide the question differently if it were being presented as a matter of first impression—are insufficient grounds for departing from prior decisions of the Court. *Accord*, *Patterson*, 491 U.S. at 171-75.

B. There Is No Special Justification For Abandoning Or Revising *Pilot Life*.

The Court's *stare decisis* principles in statutory interpretation cases counsel strongly against abandoning or revising *Pilot Life* and its progeny. Indeed, fairly applied, they foreclose any such effort.

1. Plan Sponsors And Participants Have A Strong Reliance Interest In Existing Precedent.

As an initial matter, revising *Pilot Life*'s interpretation of ERISA's exclusivity rule would injure employee benefit plan sponsors who have relied on *Pilot Life* and its progeny over the past sixteen years to develop their health benefit plans.

Today, virtually every health benefits plan in the country—regardless of whether the plan is administered by an HMO, an employer, or a traditional fee-for-service provider—limits coverage to those recommended treatments that are "medically necessary" and excludes "experimental treatments," the kinds of medically-based coverage determinations at issue here. *See* R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM 19, 211-15 (1997). When including these discretionary-judgment provisions in their plans, plan sponsors understandably relied on *Pilot Life* and its progeny and assumed that any erroneous coverage determination, including improper determinations involving medical judgment, would be subject only to a § 502(a) claim and remedy. Given the now near universality of medical necessity and experimental treatment provisions in benefits plans, judicially altering the complete preemption doctrine at

this point would be patently unfair to plan sponsors and the administrators of their health benefit plans. Absent preemption, nearly every benefits plan in the country—regardless of whether they are HMO or fee-for-service plans—could be subject to retroactive malpractice challenges and possible liability under the different laws of 50 States.

The potential financial injury here for plan sponsors and their administrators far outweighs the more limited economic harms that this Court in the past has held sufficient to require adherence to *stare decisis*. In *United States v. Title Ins. & Trust Co.*, 265 U.S. at 486, for example, the Court refused to revise 23-year-old precedent concerning a land grant in Southern California, because the decision "affected many tracts of land in California," and numerous property purchases had been made in reliance on it. And, in *NLRB v. Int'l Longshoreman's Ass'n, AFL-CIO*, 473 U.S. 61, 84 (1985), the Court refused to revisit its decisions on the work-preservation doctrine because "management and labor alike have relied on the work preservation doctrine to guide their [collective] bargaining." Here, in contrast to these limited but nonetheless decisive reliance interests, abandoning *Pilot Life* would expose nearly every health benefits plan administrator and plan sponsor in the country—including roughly 66% of all employers in the United States—to potentially massive, previously unforseen and heretofore precluded liabilities. *See* Kaiser Family Foundation & Health Research & Educational Trust, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 4 (2003) ("Kaiser Study") (observing that 66% of all employers offer health coverage to their workers).

Indeed, altering the exclusivity rule at this late date would undermine the basic policy motivating ERISA preemption. As this Court has explained, the purpose of complete preemption is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush*

Prudential, 536 U.S. at 379. Congress, too, expressly recognized that preemption was intended to create a "uniformity of decision" on which plan sponsors could rely "to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974, at 615 (Comm. Print 1976) ("ERISA Leg. Hist."). But altering ERISA's exclusivity rule would transform what were "predictable liabilities" into a morass of potential unforeseen liabilities in all 50 States. *See also Pilot Life*, 481 U.S. at 56 (noting that "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws").

2. Developments Since *Pilot Life* Was Decided Do Not Justify A Change In Preemption Principles.

Moreover, there has been no shift in the factual or legal landscape since *Pilot Life* was decided that would justify such damage to the reliance interests of employers, plan sponsors and plan administrators. To be sure, in *dicta* and non-binding opinions, some have suggested (i) that the rise of managed health care and "prospective utilization review" were "unforseen at the time of ERISA's enactment," *Cicio*, 321 F.3d at 98; (ii) that HMOs have an "incentive" to "mistreat [plan] beneficiaries," *DiFelice v. Aetna U.S. HealthCare*, 346 F.3d 442, 454 (3d Cir. 2003) (Becker, J., concurring), and "ignore the individual needs of a patient in order to improve the HMO's bottom lines," *Pegram*, 530 U.S. at 220 (describing arguments of critics of HMOs); (iii) that HMOs now exercise ultimate control over medical treatment because "coverage decisions based on medical determinations often have an outcome-determinative effect," *Cicio*, 321 F.3d at 102; and (iv) that, due to the confluence of this Court's decisions, the remedies that ERISA provides "do[] not 'make whole' plan beneficiaries

harmed by plan administrators' misconduct," *id.* at 107 (Calabresi, J., dissenting). But, to the extent that these arguments focus on traditional HMOs and HMO practices, they fail to recognize that state-law tort actions of the type in issue could apply well beyond HMOs—to, *e.g.*, PPOs and self-insured plans that also deny coverage on the basis of medical judgments. Indeed, given that traditional HMOs provide a declining and minority share of health care today, *see* Kaiser Study at 6, broadly changing ERISA preemption to address perceived problems in such HMOs alone would truly sacrifice the baby to change the bath water. In any event, the arguments are themselves either just outright wrong or in all events plainly insufficient to justify abandonment of the well-settled interpretation of statutory preemption in *Pilot Life* and its progeny.

a. Congress Was Aware Of HMOs And Their Practice Of Utilization Review When It Passed ERISA.

First, the claim that managed health care and its attributes were unforseen by Congress when it passed ERISA, *see Cicio*, 321 F.3d at 98, 102, is simply incorrect. Managed care organizations, like HMOs, are not recent phenomena at all, *see* Employee Benefit Research Institute, FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 193 (1987) ("EBRI"), and were well-established at the time of *Pilot Life*. "Although it is often thought that health maintenance organizations were a product of the 1970s, some HMOs were among the earliest providers of medical expense coverage." B. Beam & J. McFadden, EMPLOYEE BENEFITS 191 (6th ed. 2001). The Kaiser Plans, for example, date back to the 1930s. *Id.*

Congress's awareness of HMOs and utilization review procedures at the time of ERISA's passage, moreover, is well documented. In the year prior to ERISA's passage, Congress passed the Health Maintenance Organization Act of 1973 ("HMO Act"), Pub. Law No. 93-222, 87 Stat. 914 (1973)

(codified at 42 U.S.C. § 300e-14a), a "significant piece of legislation" that "sought to encourage the growth of HMOs by providing funding for their development costs and mandating that certain employers make these plans available to employees." Beam & McFadden, *supra*, at 193. As this Court recognized in *Rush Prudential*, 536 U.S. at 369, "one year before it passed ERISA, Congress itself defined HMOs in part by reference to risk, set minimum standards for managing the risk, showed awareness that States regulated HMOs as insurers and compared HMOs to indemnity or service benefits insurance plans" (internal quotation omitted).

Indeed, Congress "conducted an intensive set of public hearings in respect to HMO legislation, [dating] back to July, 1971." S. Rep. No. 93-129, *reprinted in* 1973 U.S.C.C.A.N. 3033, 3037 (1973). One Senate subcommittee itself alone conducted "extensive hearings for a period lasting over three weeks" about HMOs and heard from "witnesses represent[ing] a wide range of interests, both private and public, rural and urban, provider and consumer, and came from all regions of this country." *Id.* Contrary to the erroneous assertion that Congress simply could not have foreseen modern complaints about prospective utilization review, during these pre-ERISA hearings, this Senate subcommittee heard testimony "largely from physicians" who feared that they would be told "how to practice medicine" as a result of the HMO Act. *Id.* at 3038.

Prior to the enactment of ERISA, Congress was also demonstrably well aware of utilization review procedures. In that time-frame, Congress considered amendments to the Social Security Act that sought to emulate HMOs' cost-containment strategies by adding utilization review procedures to benefit determinations in Medicaid, Medicare and other federally-funded health programs. *See* H.R. Conf. Rep. No. 92-1605, *reprinted in* 1972 U.S.C.C.A.N. 5370, 5378 (1972) (discussing proposed amendment that required States to establish "an effective utilization review program"); *id.* at 5383 (observing that House would have authorized agency "to experiment" with

"utilization review and medical review mechanisms" but Senate rejected proposal); H.R. Conf. Rep. No. 90-1030, *reprinted in* 1967 U.S.C.C.A.N. 3179, 3192 (1967) (discussing Senate amendment to Social Security Act requiring utilization review by hospitals). Indeed, in *Pegram*, this Court held that ERISA's fiduciary duty rules were inapplicable to single physicians acting as both HMO administrators and treating physicians precisely because, in enacting ERISA, Congress did not intend to discourage HMO formation and utilization review efforts. *Pegram*, 530 U.S. at 233-34.

In short, it is factually wrong to suggest that Congress was unaware of managed care and utilization review when it passed ERISA. It had long studied HMOs, was aware of the criticism that they had the potential to influence medical treatment, but nonetheless encouraged their development as a low-cost health care alternative and sought to base federally-funded health programs, in part, on their utilization review model. S. Leimberg & J. McFadden, THE TOOLS & TECHNIQUES OF EMPLOYEE BENEFIT & RETIREMENT PLANNING 264 (2d ed. 1990) ("Congress enacted the Health Maintenance Organization Act of 1973 to encourage HMOs as a way of keeping down health care costs."). Moreover, to the extent that HMOs were in their infancy when Congress passed ERISA, ERISA had the effect of causing HMOs and the health care industry to structure themselves in a certain way—including designing plans that contain "medical necessity" and "experimental" treatment provisions. *See* Beam & McFadden, *supra*, at 193. These structures were well-established by the time of *Pilot Life*. Altering *Pilot Life* now would thus harm the industry's reliance on the opportunities for development that Congress provided, not address an unforeseen change in facts. *Stare decisis* principles governing statutory precedent thus compel adherence to, not a departure from, extant ERISA preemption jurisprudence.

b. Numerous Market And Legal Safeguards Prevent Arbitrary Or Abusive Practices By Benefits Administrators.

Second, HMOs and other health benefits plans cannot systematically mistreat plan participants. Numerous market and legal safeguards prevent arbitrary or abusive practices by benefits administrators.

Importantly, employers are the primary source of health insurance in the United States, as "[e]mployer-sponsored health benefits reach nearly three out of every five Americans." Kaiser Study at 1. The employer or plan sponsor, *not the insurance company or the HMO*, determines the kind of health care plans that plan participants will be offered—*e.g.*, HMOs, PPOs, traditional fee-for-service plans. *See* EBRI, *supra*, at 176-79. Moreover, they determine the kinds of medical services that will be covered, who will be eligible to participate in health benefits plans, and the amounts that employees will be required to contribute to the cost of their health care through payroll contribution payments, office visit co-payments and deductibles. *Id.* at 178-79. It is thus the plan sponsor, not the insurance company or the HMO, who establishes, for example, the "medical necessity" and/or "experimental" treatment provision in a plan; and it is the plan sponsor's intent—not the insurance company's intent or the HMO's intent—that determines whether those provisions apply in particular circumstances. *See generally* Leimberg & McFadden, *supra*, at 255-57 (detailing how plan sponsors formulate health benefit plans); J. Meyer, *et al.*, ASSESSING BUSINESS ATTITUDES ON HEALTH CARE 6 (Oct. 1996), *reprinted at* www.eresearch.org/Documents/Attitudes.pdf (explaining that employers shift to different kinds of health providers as method of cost containment); P. Sheedy & S. Lawson Cann, *Contain Rising Health Care Costs With Strategy & Education*, 6 WOMEN'S BUSINESS BOSTON, at 7 (Issue 2 Nov. 2003) (describing ways in which employers can alter health benefit plans to control costs).

Because employers contract for insurance coverage, and because these plan sponsors both want the benefit of their bargain and control whether an insurance company or HMO will get business in the future, they exercise significant legal and market power over HMOs and insurers and provide a major check on potential abusive practices by plan administrators. If an HMO, for example, were routinely and improperly to deny coverage (by, for example, construing "medical necessity" and/or "experimental" treatment provisions in an inappropriate or stingy way), the employer could amend the plan to prevent continuing denials, and/or it could switch its health benefit plans to different, more responsible operators. Thus, in the 1990s, many employers shifted away from traditional HMO provider plans (to PPOs and other managed care entities) in response to employee complaints about HMO service and care. *See* Kaiser Study at 6-8 (observing that employers even *offering* a *choice* of traditional HMO care had declined from 68% in 1993 to 47% in 2003). And, last year, 62% of all employers exercised their market power over plan administrators by shopping around for alternatives to their current health benefits plans. *Id.* at 2. Accordingly, the idea that HMOs and insurers have no incentive but to harm plan participants and can improperly deny coverage without consequence blinks at important, and dominant, market realities.

In addition, numerous effective safeguards exist to prevent HMOs and other managed care organizations from arbitrarily mistreating individual plan participants. For example, if plan participants believe that their benefits administrator has made an erroneous coverage determination, they may immediately challenge that decision through ERISA's civil enforcement scheme or, alternatively, receive a declaration of coverage prior to treatment. *See, e.g.*, *Meditrust Fin. Serv. Corp. v. Sterling Chem., Inc.*, 168 F.3d 211, 213 (5th Cir. 1999); *Solger v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 144 F.3d 567, 568 (8th Cir. 1998); *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 784-85 (4th Cir. 1995). Under ERISA, "[p]lans must provide an appeals procedure to participants whose claims are

partially or completely denied. The reason for claim denial must be provided in writing to the participant, and the participant must have the right to request a reconsideration of the decision. If the claim is denied again, the participant can file suit." EBRI, *supra*, at 35. ERISA plan participants can also receive immediate injunctive relief from federal courts under § 502(a) to enforce benefit provisions. *See Pryzbowski v. U.S. HealthCare, Inc.*, 245 F.3d 266, 273-74 (3d Cir. 2001). Indeed, "[t]here have been numerous cases in which courts have issued preliminary injunctions" to require an immediate benefits determination authorizing care. *Id.* (citing cases).

In these review proceedings, moreover, administrators are not free to arbitrarily interpret a benefits plan, but must implement the intent of the plan sponsor. In that regard, in the context of "medical necessity" and "experimental" treatment provisions, plan administrators are in fact and in law tethered to prevailing industry and community standards about medical care, because the terms "medical necessity" and "experimental treatment" have a customary meaning in the trade. *See* RESTATEMENT (SECOND) CONTRACTS § 202(3)(b) ("[T]echnical terms and words of art are given their technical meaning when used in a transaction within their technical field."). These objective interpretive standards guarantee that the appeals process contemplated by ERISA will protect individual plan participants from random and arbitrary eligibility determinations.

State insurance law provides a real safeguard against abuses by HMOs. As this Court has established, HMOs are subject to state insurance laws. *See Rush*, 536 U.S. at 366-70. Plan participants can also seek independent external review under state statues. Indeed, at least forty States and the District of Columbia have passed laws permitting plan participants to obtain an independent, external review of medical-necessity determinations. *See* Alaska Stat. § 21.07.050 (Michie 2001); Ariz. Rev. Stat. Ann. § 20-2537 (2000); Cal. Ins. Code § 10169 (2001); Colo. Rev. Stat. § 10-16-113.5 (2000); Conn. Gen. Stat.

§ 38a-478n (2001); 16 Del. Code Ann. § 9119 (2000); D.C. Code Ann. § 44.301.07 (2000); Fla. Stat. § 408-7056; Ga. Code Ann. § 33-20A-32 (2000); Haw. Rev. Stat. § 432E-6 (2000); 215 Ill. Comp. Stat. § 125/4-10 (2000); Ind. Ins. Code Ann. § 27-13-10.1-1 (2000); Iowa Code Ann. § 514J (2000); Kan. Stat. Ann. § 40-22a13 (2000); Ky. Rev. Stat. Ann. § 304.17A-623 (2001); La. Rev. Stat. Ann. § 22:3081 (2000); Me. Rev. Stat. tit. 24-A, § 4312 (2000); Md. Code Ann. Ins. § 15-10A-01 (2001); Mass. Gen. Laws Ann. ch. 1760 § 14 (2001); Mich. Comp. Laws § 550.1907 (2001); Minn. Stat. § 62Q.73 (2000); Mo. Rev. Stat. § 376.1385 (2000); Mont. Code Ann. § 33-37-102 (2000); N.H. Rev. Stat. Ann. § 420-J:5 (2000); N.J. Stat. Ann. § 26:2S-11 (2001); N.M. Adm. Code tit. 13, § 10.17.24 (2000); N.Y. Ins. Law § 4904 (McKinney 1999); N.C. Gen. Stat. § 58-50-62 (1999); Ohio Rev. Code Ann. § 1751.84 (Anderson 2001); Okla. Stat. tit. 63, § 2528.3 (2000); Or. Rev. Stat. § 743-857 (2001); 40 Pa. Cons. Stat. § 991.2162 (1998); R.I. Gen Laws § 23-17.12-10 (2001); S.C. Code Ann. § 38-71-1970 (2000); Tenn. Code Ann. § 56-32-227 (2001); Tex. Ins. Code § 21.58A (Vernon Supp. 2001); Utah Code Ann. § 31A-22-629 (2000); Vt. Stat. Ann. tit. 8, § 4089f (2001); Va. Code Ann. § 38.2-5901 *et seq.* (2001); Wash. Rev. Code § 48.43.535 (2001); W. Va. Code § 33-25C-6 (2001); Wis. Stat. § 632.835 (2000). In addition, many of these statutes contain expedited review procedures. In New York, for example, plan participants can receive expedited external review within three days of a benefits determination. *See Regulators: External Review Works For New York Consumers' Health Claims*, BEST'S INS. NEWS, 2003 WL 59121106 (Sept. 12, 2003).

To the extent that these market and other legal safeguards prove inadequate, the State always has available to it the ability to mandate the provision of specific benefits by insured plans. *See* 29 U.S.C. § 1144. The tort action authorized here and in other cases, however, is not an insurance law and, at least in some contexts, could extend well beyond the insurance

industry to include even self-insured plans. *See Pilot Life*, 481 U.S. at 51-53.

There is, in short, no pattern of abuse by HMOs that justifies abandonment of statutory precedent such as *Pilot Life*. On the contrary, market and legal safeguards have responded repeatedly and effectively to address concerns about HMO practices.

c. HMOs Do Not Control Medical Treatment Decisions.

Third, it is equally wrong to suggest that managed care organizations control medical treatment decisions. Those decisions are in fact made by the patient and the treating physician. Certainly nothing about these realities has changed since *Pilot Life* was decided.

Except where a treating physician and health benefits administrator are one and the same—in which case the physician will always be liable under state law for an erroneous treatment decision (and under ERISA for an erroneous benefits decision)—insurance companies and other health benefits administrators do not make medical treatment decisions. The benefits administrator does not recommend medical treatment or deny medical treatment. The benefits administrator simply determines whether the plan will pay for a particular treatment. It decides only "pre-certification benefit decisions on behalf of the plan." *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). "[The] patient and her treating physicians retai[n] ultimate decision-making authority regarding her medical care." *Id.* Any other view of benefits determinations involving medical judgment, indeed, would be inconsistent with Department of Labor regulations, which expressly treat "medical necessity" and other medically-based eligibility decisions as part of the benefits determination process. *See generally* 29 C.F.R. § 2650.503-1.

Individuals would no doubt prefer for all treatments to be covered by their health benefits plan. But, plans do not cover all treatments and, when coverage is denied, individuals remain free to pay for the treatment themselves and, if appropriate, sue under ERISA to recover any benefits improperly denied. Individuals commonly pay health care costs out of pocket and only later seek to recover their expenses. *See Thompson*, 202 F.3d at 1073; *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 56 (1st Cir. 1999); *Castillo v. Cigna Healthcare*, No. 00-15573, 2001 WL 638403, at *2 (9th Cir. June 7, 2001); *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 962 (7th Cir. 2000), *aff'd* 536 U.S. 355 (2002); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1005 (9th Cir. 1998). Moreover, charitable organizations and medical research facilities provide financial support and, sometimes, the care itself when coverage is denied for "experimental" treatments, for example. *See Community Garage Sale is Fund-Raiser for Slidell Child*, TIMES-PICAYUNE, 2003 WL 60073003 (Oct. 30, 2003) (charitable aid); L. Hugh, *Troops in Korea Help Grand Ledge Student*, LANSING STATE JRNL., 2003 WL 63333706 (Oct. 6, 2003) (same); *MMI AIDS Drug Showing Considerable Promise*, WMRC DAILY ANALYSIS, 2003 WL 63612472 (Oct. 7, 2003 (study).

The fact that medical treatment choices may be financially difficult, and a plan participant may be "perhaps unable or unwilling to undergo costly treatment not covered by the plan . . . does not mean [the] plan administrator control[s] her medical care." *Thompson*, 202 F.3d at 1074. Individuals "must sometimes choose a course of action within a limited context of relatively distasteful options" but that does not mean the choice is "compelled" or involuntary. *Cherchi v. Mobil Oil Corp.*, 693 F. Supp. 156, 163 (D.N.J), *aff'd*, 865 F.2d 249 (3d Cir. 1988) (internal quotations and citation omitted). The choice about treatment is still that of the patient and the doctor; the plan administrator only decides whether the plan will pay for their choice. Certainly, nothing about these realities has changed since *Pilot Life*, and accordingly,

complaints about HMO influence on medical treatment choices is not a basis for revisiting that statutory precedent.

d. Alteration of ERISA Preemption Jurisprudence Is Not An Appropriate Response.

Finally, altering ERISA preemption principles is not the proper response to any perceived gap in ERISA's remedial scheme. Judges Calabresi and Becker have opined that ERISA is failing because it provides no consequential damages remedy for improper coverage determinations. But, as even those judges admit, the argument that additional remedies are needed under ERISA is an argument for legislative action or reconsideration by this Court of its own consequential damages rulings, not for "stretching to avoid preemption in order to allow state actions for consequential damages." *Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting); *see also*, *DiFelice*, 346 F.3d at 465-66 (Becker, J., concurring) (suggesting potential legislative solutions to provide additional compensation for individuals who are improperly denied medical coverage). Indeed, the ability of Congress to "alter what [the Court] ha[s] done" counsels strongly against altering *Pilot Life* and its progeny. *Hilton*, 502 U.S. at 202.

3. Altering The Court's Preemption Jurisprudence Would Harm Plan Participants By Reducing The Availability And Scope Of Affordable Health Insurance.

Altering ERISA preemption principles is not only unnecessary to protect plan participants, but would affirmatively harm them going forward.

It is beyond peradventure that imposing state law malpractice liability on benefit plan administrators or plan sponsors for erroneous coverage determinations would increase the cost of health plans. Such liability would (i) increase the cost of administering the health plan to the insurer or benefits

administrator, which would be passed on to employers, (ii) increase costs to employers directly where the employer administers the health plan itself, and (iii) increase administration costs due to the lack of uniformity among state law and the potential applicability of punitive damages and other remedies not available under federal law. *See* M. Langan, *ERISA Protections for Health Plans Are Weakening*, TOWERS PERRIN MONITOR (May 2003). Importantly, this increased cost would not be limited to employers who provide health benefits through HMOs or other managed care providers, because almost all health benefit plans—from those operated by HMOs to traditional fee-for-service plans—include medical necessity clauses and exclusions for experimental treatment.

Because employers are highly sensitive to cost increases in health care plans, they would quickly respond to these increasing health care costs. *See* EBRI, *supra*, at 185 (observing that in times of rising costs "virtually all employers offering health insurance coverage to their employees have taken steps to manage costs"). Specifically, employers would shift the higher costs of health benefits to employees through higher premiums, co-pays and deductibles. *See id.* ("Changes most commonly initiated by employers include imposing or increasing cost-sharing requirements."). "Another technique for controlling employer health care costs [would be] to restrict the use of certain benefits under the plan." *Id.* at 187. This could include reducing or eliminating available benefits, defining certain procedures as experimental or not necessary and thus not covered in any circumstance, or reducing the number of employees eligible for health care coverage. *See* Kaiser Study at 141. In short, subjecting benefit determinations to state-law malpractice claims would perversely cause plan sponsors to systematically restrict coverage, which is not in the interests of plan participants.

In all events, imposing such liability would reduce the number of individuals participating in health benefit plans. As employers shift costs to employees, their "health coverage

becomes increasingly burdensome and can result in some workers' inability to afford health insurance." Meyer, *supra*, at 36. As a result, "health coverage will be priced out of range for more and more working families, especially lower-paid workers, and this will only add to the numbers of uninsured and underinsured already in the system." *Id.* Alternatively, health benefit plans could become so expensive that some employers might chose to forgo providing them altogether. *See* Kaiser Study at 141 (noting that some employers reported that they were likely "to restrict employee eligibility for coverage or drop coverage entirely" in the face of rising costs). As a result, only those individuals who could afford higher-priced insurance would receive any benefit from the Court's alteration of preemption jurisprudence.

This is not an unlikely scenario but the precise result that concerned Congress when passing ERISA:

> [S]ince these plans are voluntary on the part of the employer . . . , it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans.

S. Rep. No. 93-383, at 18-19 (1973), *reprinted in* 1 ERISA Leg. Hist. at 1086-87. "[Employers] do have some choice with respect to a voluntary pension plan, and while we had every desire to make it as splendid a set of protective requirements as we could, for the working people of this country, we had to be careful. If we overdid it, quite obviously we would have people writing us letters saying: 'How come you helped us so much that now we have no pension plan at all because our employer has decided he cannot afford it any longer under the new rules?'" H.R.2 Floor Debate (statement of Rep. Conable), *reprinted in* 2 ERISA Leg. Hist. at 3451.

4. The States' Interest In Regulating The Practice Of Medicine Does Not Justify A Change In Existing Preemption Principles.

Finally, there is no state interest at issue here that justifies altering the Court's ERISA preemption jurisprudence. At the petition stage, several State Attorneys General suggested that States should be allowed to impose liability on benefit plan operators that deny health care coverage due to improper medical judgment in light of the State's traditional interest in "protecting the health and welfare of its citizens." Br. of *Amici* State of Texas *et al.* at 3, in *Roark v. Humana, Inc.*, No. 02-1826 (filed Jul. 17, 2003). This argument is incorrect, because it misunderstands the nature of a benefits determination, ignores the extensive regulatory power that States currently exercise, and would so expand the regulatory authority of States as to undo any limit on liability.

The primary flaw in this argument is that it wrongly assumes coverage determinations are medical treatment decisions merely because plan administrators must sometimes reference medical standards. It is in fact common for courts to look to the medical profession to understand contracts or even statutes that contain terms that relate to a medical treatment or practice. *See* 11 WILLISTON ON CONTRACTS § 32:4 (4th ed. 1999) (discussing *Rodgers v. Rodgers*, 216 S.E.2d 322 (Ga. 1975), a case in which court looked to medical profession to interpret term "doctor" in contract). Here, too, benefits administrators look to the medical community to understand whether a recommended treatment is "medically necessary" or "experimental" within the meaning of a benefits plan. *See generally Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1968 (2003) (discussing process by which benefits administrators make coverage decisions in context of holding that treating physician rule does not apply to ERISA plans). But this reference to medical custom is no more a treatment decision than a court's analysis of medical standards in interpreting a contract is a medical decision. In both instances, the reference to medical customs and standards

is part of the interpretive process, not a medical treatment decision in and of itself.

A simple example illustrates the point. In the context of organized labor, health benefit plans are typically defined through collective bargaining agreements, which can provide that an employer will pay for "medically necessary" treatments. Putting ERISA aside, if the employer and employee disagreed over whether a medical treatment was "necessary" under a collective bargaining agreement, the dispute would undoubtedly fall within the scope of § 301 of the LMRA, 29 U.S.C. § 185(a), because the dispute would relate to the interpretation of a collective bargaining agreement. Under the LMRA, the nature of the dispute would not change if the employer (or the union or, for that matter, an arbitrator or a court) consulted medical textbooks and local physicians to aid its understanding of the agreement and the so-called "law of the shop." *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985). After all, the employer is not practicing medicine but making a determination about the meaning of the labor agreement. And § 301 of the LMRA requires that all "questions relating to what the parties to a labor agreement agreed, and what legal consequences were intended to flow from breaches of that agreement, must be resolved by reference to uniform federal law, whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort." *Id.*

Here, too, the conduct at issue does not involve a medical decision or even the provision of medical care but an interpretation of a contract, namely a health insurance contract. Moreover, like disputes over the interpretation of collective bargaining agreements, disputes over the meaning of such health benefits plans are not an area of traditional regulation by the States; on the contrary, like the LMRA and its "law of the shop," ERISA intended that the interpretation of benefits plans be a matter of exclusive federal concern. *See Pilot Life*, 481 U.S. at 54; *Metropolitan Life Ins. Co v. Taylor*, 481 U.S. at 67. Indeed, Congress specifically referenced § 301 of the LMRA

when describing ERISA's enforcement scheme, *see* H.R. Conf. Rep. No. 93-1280, at 327 (1974), *reprinted in* 3 ERISA Leg. Hist. at 4594, and this Court has held that this reference "makes clear [Congress's] intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." *Pilot Life*, 481 U.S. at 56.

In addition, this argument of state interest ignores that, under ERISA, this Court has repeatedly found preemption in areas of traditional state regulation. For example, in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130-31 (1992), this Court held traditional state worker's compensation laws preempted because they "impos[ed] requirements" that were not part of ERISA. *See also FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (holding motor vehicle law preempted). Moreover, this Court has never hesitated to preempt state health and safety laws in favor of a uniform federal law. *See Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 546-49 (2001) (holding cigarette laws preempted); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 103 (1992) (rejecting argument that OSHA fails to preempt state laws "designed to promote worker safety").

In all events, States can regulate in the true area of interest to them—the health and safety of their citizens—under existing jurisprudence. Most notably, States can, and do, through traditional malpractice law regulate the decisions of treating physicians, and ERISA does not preclude participants from suing a treating physician who erroneously determines that a medical treatment is not necessary. In addition, if a State believes that a certain medical treatment is important to the health of its citizens but not covered under existing contracts, it can require insurance companies to cover the treatment as part of its general authority to regulate insurance. *See* 29 U.S.C. § 1144; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985) ("If a state law 'regulates insurance,' as mandated- benefit laws do, it is not pre-empted [by ERISA].").

Finally, States can enact, and have enacted, independent utilization review statutes. *See supra* pp. 20-21.

Redefining a benefits determination to be the "practice of medicine" itself would, however, expand the authority of States in new and unacceptable ways. States, for example, could require any benefits administrator, even out-of-State administrators whose coverage determinations impact in-State plans, to adhere to state licensing requirements for medical practitioners. *See* S. Kanwit, *Should HMO Coverage Decisions Be Subject To Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR, at 12-13 (May 2003). Indeed, if administrators are subject to traditional malpractice law—as one would expect if they are "practicing medicine"—benefits administrators would have a duty to inquire about the *propriety* of care, and thus be subject to the same malpractice liabilities as treating physicians whenever they fail to exercise that judgment properly, either in denying *or* granting coverage. *Id.* But allowing States this kind of authority over plans would subject interstate benefit plans to myriad and possibly conflicting state laws. Nothing could be further from § 502's "complete preemption" purpose.

CONCLUSION

For these reasons, the decision of the court below should be reversed.

Respectfully submitted,

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In the Supreme Court of the United States

AETNA HEALTH INC., FKA AETNA U.S. HEALTHCARE INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS INC., PETITIONER

v.

JUAN DAVILA

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION, PETITIONER

v.

RUBY R. CALAD, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTION PRESENTED

Under *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), certain state-law claims can be removed from state to federal court if they fall within the scope of the civil enforcement provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a), and are thereby "completely preempted." The question presented is whether ERISA completely preempts state-law claims by an ERISA plan participant or beneficiary against a health maintenance organization (HMO) where the claims challenge an HMO's decision to deny coverage of treatment or care that was prescribed by the claimant's physician but that the HMO decided was not authorized under the plan's "medical necessity" proviso.

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In the Supreme Court of the United States

No. 02-1845

AETNA HEALTH INC., FKA AETNA U.S. HEALTHCARE INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS INC., PETITIONER

v.

JUAN DAVILA

No. 03-83

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION, PETITIONER

v.

RUBY R. CALAD, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

This case concerns the scope of "complete preemption" under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a), as applied to state-law claims against a health maintenance organization (HMO). Because the Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, see 29 U.S.C. 1002(13), 1136(b), which includes Section 502(a), the United States has a substantial interest in

ensuring that ERISA's complete preemption principle is appropriately applied.

STATEMENT

1. *Aetna Health Inc.* v. *Davila*

a. Petitioner Aetna Health Inc.'s predecessors provided HMO coverage to respondent Juan Davila pursuant to an ERISA plan sponsored by Davila's employer. 02-1845 Pet. App. 4a, 67a. The agreement between Aetna and the employer provided that Aetna would contract with participating physicians who were independent contractors and solely responsible for health services rendered to covered patients. *Id.* at 98a. The agreement gave Aetna "complete authority to review all claims for Covered Benefits," including "discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under th[e] Group Agreement." *Id.* at 102a.

The agreement required benefits to be "[m]edically [n]ecessary" to be covered and specified that "[f]or the purpose of coverage, [Aetna] may determine whether any benefit provided under the [Certificate of Coverage] is [m]edically [n]ecessary." 02-1845 Pet. App. 122a. Among other things, "medically necessary" means that a service or supply "must * * * be no more costly * * * than any equally effective service or supply" in satisfying certain standards of medical efficacy. *Id.* at 122a-123a. The agreement provided that its coverage "does not restrict a Member's ability to receive health care benefits that are not, or might not be, [c]overed [b]enefits." *Id.* at 177a.

b. In April 2000, Davila's primary care physician prescribed Vioxx for Davila's arthritis. 02-1845 Pet. App. 67a, 76a. Aetna refused to pay for the prescription, which led the physician to contact Aetna concerning the refusal. *Id.* at 77a. In May 2000, an Aetna representative informed the physician that, under its formulary policy, Aetna would approve Vioxx only if Davila "has a diagnosis of osteoarthritis or acute pain and has a contraindication, intolerance, allergy to or a documented adequate trial" of at least two other covered drugs. *Id.* at 80a; see *id.* at 4a, 67a-68a. Davila began taking one of those other drugs (a generic drug, naprosyn), which allegedly led to a hospitalization for bleeding ulcers, a near-heart attack, and internal bleeding. *Id.* at 5a, 68a, 77a.

After his hospitalization, Davila sued Aetna in Texas state court for violations of the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001 *et seq.* (West Supp. 2004) (reproduced at 02-1485 Pet. App. 56a-63a). See *id.* at 68a-70a. The THCLA requires a health insurance carrier, HMO, or other managed care entity "to exercise ordinary care when making health care treatment decisions" and imposes liability for damages for harm to an insured or enrollee proximately caused by its failure to exercise such care. Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (West Supp. 2004). The THCLA defines "[h]ealth care treatment decision" to mean

> a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

Id. § 88.001(5). It is a defense to an action asserted against an insurer, HMO, or other managed care entity that neither it nor any of its employees or agents "controlled, influenced, or participated in the health care treatment decision" and "did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee." *Id.* § 88.002(c).

Davila alleged that Aetna's adherence to its policies on the use of Vioxx amounted to a failure to use ordinary care in making a health care treatment decision that affected the

quality of the treatment Davila received. 02-1845 Pet. App. 68a-69a. He further alleged that Aetna was liable for punitive damages because Aetna knew its policy involved a risk of serious injury or death. *Id.* at 70a-71a.

c. Aetna removed the action to federal court based on the "complete preemption" doctrine recognized in *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987). 02-1845 Pet. App. 89a. Under that doctrine, a state-law claim that falls within the scope of the civil enforcement provisions in Section 502(a) of ERISA, 29 U.S.C. 1132(a), is deemed to be a federal claim subject to removal. *Taylor*, 481 U.S. at 65-67. Aetna argued that Davila's state-law claims were within the scope of Section 502(a) because they were based on Aetna's "allegedly wrongful conduct of denying benefits." 02-1845 Pet. App. 87a.

Davila filed a motion to remand the case to state court, which the district court denied. 02-1845 Pet. App. 30a-35a. The district court reasoned that while ERISA would not completely preempt a claim challenging the quality of medical care a participant received, the claim here, "fairly construed, actually challenges the administration of health benefits under an ERISA plan." *Id.* at 33a-34a. Because Davila chose not to refile his state-law claims as ERISA claims, the district court dismissed his state-law claims with prejudice. *Id.* at 34a-35a.

2. *CIGNA HealthCare of Texas, Inc.* v. *Calad*

a. Ruby Calad became a member of CIGNA HealthCare's HMO through an ERISA plan provided by her husband's employer. 03-83 Pet. App. 3a, 33a. Under the plan, hospital benefits would not be paid for any day in excess of the number of days certified through a pre-admission certification (PAC) or continued stay review (CSR). CIGNA Opp. Mot. Remand App. 22.

In September 1999, Calad was admitted to a hospital for a hysterectomy. Cause No. 00-09041 Pl. Orig. Pet. para. 4.

During pre-authorization procedures, CIGNA allegedly informed her that it authorized only one day of hospitalization following the surgery. 03-83 Pet. App. 34a. On the second day after surgery, a CIGNA representative allegedly informed Calad's treating physician that CIGNA would not extend her hospital stay unless she had hemorrhaging, fever, or high blood pressure; without those symptoms, Calad would have to pay the cost of an extended hospitalization. *Id.* at 34a-35a. Calad was discharged, but she suffered complications that caused her to return to the emergency room a few days later. *Id.* at 3a. Alleging that she did not qualify for a continued hospital stay under CIGNA's medical necessity criteria and was unable to pay for the hospitalization, she sued CIGNA in state court under the THCLA for failing to use ordinary care in its medical decisions. See *id.* at 3a, 30a, 35a.

CIGNA removed the action to federal court under the complete preemption doctrine. See 03-83 Pet. App. 30a-31a. The district court denied Calad's motion to remand and dismissed her state-law claims with prejudice because she chose not to amend her pleading to bring an ERISA claim. *Id.* at 40a.

3. *The court of appeals' decision*

The Fifth Circuit consolidated appeals by Davila and Calad and reversed the district courts' refusals to remand their claims to state court. 02-1845 Pet. App. 2a-3a. Removal of the claims by Davila and Calad was improper, the court held, because their claims were not covered by relevant provisions of Section 502(a) authorizing a suit for breach of fiduciary duty or a claim for benefits. *Id.* at 10a-20a.

In particular, the court concluded that respondents' claims were not within Section 502(a)(3) of ERISA, 29 U.S.C. 1132(a)(3), which authorizes suits to enjoin violations of ERISA or the plan or to obtain "other appropriate equitable

relief" to redress such violations or enforce ERISA or the plan, because respondents sought damages rather than equitable relief. 02-1845 Pet. App. 10a. The court also concluded that the claims were not within the scope of Section 502(a)(2) of ERISA, 29 U.S.C. 1132(a)(2), which authorizes a plan participant, beneficiary, or fiduciary or the Secretary to obtain "appropriate relief" for the plan against a fiduciary who breaches ERISA duties, because petitioners "were not acting as plan fiduciaries when denying [respondents] medical treatment." 02-1845 Pet. App. 12a.

Finally, the court of appeals concluded that the claims by Davila and Calad did not fall within the scope of Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), which allows a suit by a plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. 1132(a)(1)(B); see 02-1845 Pet. App. 15a-20a. The court reasoned that Section 502(a)(1)(B) "creates a cause of action for breach of contract," which permits patients to obtain the benefits due "[w]hen a plan administrator incorrectly interprets the plan to deny benefits." *Id.* at 16a. "[B]y contrast," the court held, "[respondents] assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan." *Ibid.*

SUMMARY OF ARGUMENT

A. The Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, "completely preempts" respondents' state-law claims. In *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), the Court concluded that ERISA's civil enforcement provisions provide an exclusive set of remedies and therefore preempt state-law claims that fall within the scope of those provisions. In *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), decided the same day as *Pilot Life*, the Court held that such state-law

claims are "completely preempted"—*i.e.*, are removable from state to federal court as a jurisdictional matter and preempted by federal law on the merits. "Complete preemption" reflects a Congressional intent for Section 502(a) to provide the exclusive remedies for claims that fall within the scope of that section.

B. Respondents' state-law claims are completely preempted because they fall within the scope of Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B). That provision affords plan participants and beneficiaries a cause of action to obtain benefits or enforce rights under an ERISA plan. The state-law claims in these cases clearly attempt to enforce rights under an ERISA plan, because petitioners' liability is dependent on a showing that respondents were entitled to have petitioners pay for benefits under the plans. Because respondents' state-law claims thus fall within the scope of Section 502(a)(1)(B) of ERISA, they are subject to complete preemption, and the federal courts accordingly had removal jurisdiction over these cases.

C. The court of appeals held that respondents' claims are not completely preempted because they sound in tort, while Section 502(a)(1)(B), in the court's view, creates a cause of action for breach of contract. That distinction is untenable; this Court has repeatedly held—in *Pilot Life*, in *Taylor*, and in *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990)—that tort-based claims are preempted or completely preempted by ERISA's civil enforcement provisions in Section 502(a). The Court has never suggested that preemption under Section 502(a) depends on the categorization of a claim as contract-based or tort-based. To the contrary, the Court has stated that Section 502(a) provides exclusive remedies; the fact that a plaintiff seeks tort-type remedies or other remedies not authorized in Section 502(a) only reinforces the conclusion that the plaintiff's claim is preempted or completely preempted. Although the court of appeals purported

to find support for its view in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), that case supports and reaffirms the conclusion that state-law claims seeking remedies not authorized by Section 502(a) of ERISA are preempted under the principles of *Pilot Life*, *Taylor*, and *Ingersoll-Rand*.

D. *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), does not alter that conclusion. In *Pegram*, the Court held that an HMO physician, who was both treating the patient and deciding whether treatment was covered by a plan, was not acting as an ERISA fiduciary when she made a "mixed" eligibility and treatment decision. *Pegram*'s conclusion about the existence of a fiduciary duty under ERISA, however, has little to do with whether respondents' claims fall within the scope of a Section 502(a)(1)(B) claim for benefits. Moreover, *Pegram*'s holding that a physician making a medical necessity determination is not an ERISA fiduciary is properly limited to cases, such as *Pegram* itself, in which the physician is a treating physician serving simultaneously in a medical-treatment and benefits-determination role. ERISA and the governing regulations of the Secretary of Labor make clear that where, as here, the HMO and its representatives are not treating the patient but are making benefits determinations under an ERISA plan, they may serve in an ERISA fiduciary capacity.

E. ERISA is designed to provide participants and beneficiaries with the benefits promised by their plans and other appropriate equitable relief. While the remedies available under Section 502(a) of ERISA are not as broad as the tort remedies and punitive damages sought by respondents, ERISA's civil enforcement scheme—which the complete preemption doctrine makes exclusive—nonetheless effectuates the congressional balance between providing prompt and appropriate remedies for claimants and encouraging the formation and growth of employee benefit plans. The ERISA regime protects claimants and permits remedies

that are effective for most claimants, including an injunction ordering an HMO to pay for proposed treatment before it is provided, appropriate equitable relief to redress violations of ERISA or an ERISA plan, important procedural protections under the recently revised claims regulations promulgated by the Department of Labor pursuant to Section 503 of the Act, 29 U.S.C. 1133, independent review of HMO medical-necessity decisions if state law so provides, and a possible state-court suit against a treating physician for malpractice and against an HMO when it is vicariously liable for a treating physician's decisions. Permitting state-law damage actions concerning what are at bottom coverage disputes in addition to those protections and remedies under ERISA itself would undermine the exclusivity of the remedies ERISA does provide. It would also undermine the uniform administration of plans operating in more than one State Moreover, by increasing costs through awards of or exposure to punitive damages and other state-law remedies in ways that cannot readily be predicted or budgeted, allowance of state-law damage actions against HMOs or other insurers for an allegedly wrongful denial of a claim for benefits could frustrate ERISA's goal of promoting the interests of employees in having their employers provide and maintain adequate health plans.

ARGUMENT

ERISA COMPLETELY PREEMPTS RESPONDENTS' STATE-LAW CLAIMS BECAUSE THEY FALL WITHIN THE SCOPE OF SECTION 502(a)

A. State-Law Claims Within The Scope Of Section 502(a) Are Removable From State To Federal Court

1. Under 28 U.S.C. 1441(b), "[a] civil action filed in a state court may be removed to federal court if the claim is one 'arising under' federal law." *Beneficial Nat'l Bank* v. *Anderson*, 123 S. Ct. 2058, 2062 (2003). Ordinarily, Section

1441(b) authorizes removal only when the federal question appears on the face of a well-pleaded complaint, but not when preemption is simply raised as a federal defense to a plaintiff's suit. *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 63 (1987). But certain statutes so completely occupy an area Congress has chosen to regulate exclusively as federal law, with a federal cause of action, "that any civil complaint raising this select group of claims is necessarily federal in character." *Taylor*, 481 U.S. at 63-64. With respect to those statutes, a claim that on its face raises only state-law claims but that also falls within the scope of the federal cause of action will be considered to raise the federal claim. See, *e.g.*, *Beneficial Nat'l Bank*, 123 S. Ct. at 2063; *Caterpillar Inc.* v. *Williams*, 482 U.S. 386, 393 (1987); *Taylor*, 481 U.S. at 65.

2. ERISA's enforcement provisions have such a "complete preemption" effect. That conclusion follows from two basic premises. The first premise, established by *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), is that ERISA's civil enforcement provisions—and, in particular, Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B)—provide an exclusive remedy; they therefore preempt any state-law claims that fall within their scope. The second premise, established by this Court's decision the same day in *Taylor*, is that the preemptive force of ERISA's civil enforcement provisions gives rise to complete preemption, and thus federal removal jurisdiction over claims that are pleaded under state law but that fall within the scope of Section 502(a).

a. In *Pilot Life*, an ERISA plan participant unsuccessfully sought disability benefits from the ERISA plan's insurer for a back injury at work. 481 U.S. at 43. The participant brought state-law tort and contract claims against the insurer in state court, seeking compensatory and punitive damages for the failure to provide benefits. *Id.* at 43-44.

This Court held that suits "asserting improper processing of claims under ERISA-regulated plans [are to] be treated as federal questions governed by § 502(a)" of ERISA, and are preempted. *Id.* at 56.

The Court's conclusion in *Pilot Life* was based largely on its determination that "ERISA's civil enforcement remedies were intended to be exclusive." 481 U.S. at 54. ERISA's civil enforcement scheme was carefully crafted by Congress, balancing "the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Ibid.* The Court concluded that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Ibid.* See also *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 145 (1990) (state-law cause of action preempted because it "purports to provide a remedy for the violation of a right * * * exclusively enforced by § 502(a)[3]").

b. *Taylor* was decided the same day as *Pilot Life*. As in *Pilot Life*, an ERISA plan participant sought disability benefits for a back injury he had suffered at work. 481 U.S. at 61. As in *Pilot Life*, the insurer of the ERISA plan found that the plaintiff was not disabled and therefore not eligible for benefits. *Ibid.* Unlike in *Pilot Life*, the plaintiff brought suit in *state* court, asserting state-law "contract and tort" claims, *id.* at 62, and seeking both the disability benefits that he believed had been wrongfully denied and damages for his "mental anguish." *Ibid.* The insurer removed the case to federal court.

This Court held that "this suit, though it purports to raise only state law claims, is necessarily federal in character by virtue of the clearly manifested intent of Congress," and that it was accordingly "removable to federal court by the defen-

dants" under the complete preemption doctrine. *Taylor*, 481 U.S. at 67. The Court noted that its companion decision in *Pilot Life* held that "state common law causes of action asserting improper processing of a claim for benefits under an employee benefit plan regulated by [ERISA] are preempted by the Act." *Id.* at 60. Although a mere preemption defense is not ordinarily a sufficient basis for removal jurisdiction, the Court explained that Congress had "clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." *Id.* at 66. Accordingly, the Court held that it was appropriate "to recharacterize a state law complaint displaced by § 502(a)(1)(B) as an action arising under federal law." *Id.* at 64.[1]

B. Respondents' Claims Fall Within The Scope Of Section 502(a)(1)(B)

1. *Pilot Life* and *Taylor* establish that claims that fall within the scope of Section 502(a)(1)(B) are subject to complete preemption. In each of those cases, the plaintiffs could not have been successful on their contract and tort claims unless they could show that they were in fact entitled to have the defendants pay for benefits under their ERISA plans. In *Pilot Life*, for example, the plaintiff sought, *inter*

[1] In contrast to "complete preemption" of state causes of action that fall within the scope of Section 502(a) under *Taylor*, "ordinary" preemption of state law under Section 514(a) of ERISA, 29 U.S.C. 1144(a), does not by itself permit removal of a state-court action to federal court. *Taylor*, 481 U.S. at 64; *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1 (1983). A state law may be saved from "ordinary" preemption under ERISA's insurance saving clause, see 29 U.S.C. 1144(b)(2)(A), even in a case in which the underlying claim is removable from state to federal court under the complete preemption doctrine. That would occur, for example, if the state law's sole effect is to add a mandatory plan term that is enforceable only through an ERISA Section 502(a) action. See *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379-380 (2002); see also *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376-377 (1999).

alia, "[d]amages for failure to provide benefits under the insurance policy." 481 U.S. at 43. In *Taylor*, the plaintiff sought, *inter alia*, "compensatory damages for money contractually owed Plaintiff." 481 U.S. at 61. In both cases, the plaintiffs' claims obviously could not have been successful if it were ultimately determined that they were not entitled to the benefits at issue.

Because the plaintiffs in *Pilot Life* and *Taylor* brought claims that depended on a showing that they were entitled to have the defendants pay for benefits under their ERISA plans, the Court had no difficulty in concluding in each case that the plaintiff's claims fell within the scope of Section 502(a)(1)(B). Indeed, the showing of entitlement to payment that plaintiffs had to make in *Pilot Life* and *Taylor* was essentially the same showing that would have been required for them to bring a successful suit under Section 502(a)(1)(B), which creates a cause of action "to recover benefits due [a participant] under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. 1132(a)(1)(B). Accordingly, the state-law claims in those cases were squarely preempted.

2. Just as in *Pilot Life* and *Taylor*, respondents' claims fall within the scope of Section 502(a)(1)(B) because they require adjudication of respondents' entitlement to have petitioners pay for benefits under their ERISA plans. They also seek remedies additional to those provided under Section 502(a)(1)(B). They are therefore completely preempted.[2]

a. Respondent Davila's state-law action alleges that Aetna, through its prescription drug formulary policies, "controlled, influenced, participated in and made decisions

[2] Because the state-law claims in these cases depend on a showing that respondents were entitled to benefits under their ERISA plans, these cases do not present the question whether a state-law claim that does not require adjudication of rights under an ERISA plan may nonetheless fall within the scope of Section 502(a) and therefore be completely preempted.

which affected the quality of the diagnosis, care, and treatment provided to" him; that Aetna thereby "violat[ed] the duty of ordinary care" set forth in Texas law; and that "[s]uch violation of ordinary care was the proximate cause of [Davila's] damages." 02-1845 Pet. App. 69a. In particular, Davila alleges that Aetna did not exercise due care when it concluded that he could not obtain Vioxx under the plan unless and until he had first tried other medications to treat his condition. *Id.* at 67a-69a.

As was true of the claims in *Pilot Life* and *Taylor*, Davila's state-law claim necessarily requires adjudication of Davila's right to obtain payment for Vioxx under his ERISA plan. Specifically, Davila's claim requires a showing that Davila was entitled to payment for Vioxx either under the literal terms of the plan or under any provision of law incorporated into the plan—*i.e.*, any federal law applicable to the plan or any state law applicable to the plan that is not preempted (or saved from preemption) under Section 514(a). If he was not so entitled, then Aetna's failure to pay for the drug was both justified and not the proximate cause of any injuries Davila suffered. In other words, Davila's state-law claim depends on the showing that would have been necessary under Section 502(a)(1)(B) of ERISA "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. 1132(a)(1)(B).

Under the principles of *Pilot Life* and *Taylor*, claims like Davila's that require a showing that the claimant could have recovered on a Section 502(a)(1)(B) claim are subject to complete preemption under ERISA. That is more, not less, clear when such state-law claims involve remedies not available under Section 502(a)(1)(B). Although Davila has purported to plead his claim under an alternative state-law cause of action that provides for remedies in addition to those available under ERISA, his claim nonetheless "is in

reality based on federal law" and is therefore completely preempted. *Beneficial Nat'l Bank*, 123 S. Ct. at 2063.

b. Similarly, Calad's claim in No. 03-83 is completely preempted. The basis for her state-law complaint is an asserted right under her ERISA plan to obtain what she viewed as medically necessary treatment—in her case, more than one day of hospitalization after a hysterectomy, as recommended by her treating physician. Calad alleged that CIGNA interfered with that right by informing Calad and her treating physician that CIGNA would not pay for an extended hospital stay because she did not qualify under CIGNA's medical necessity criteria for extended hospital coverage. 03-83 Pet. App. 34a-35a. If Calad did not have a legal right under her ERISA plan to payment for a medically necessary additional period in the hospital, then her state-law claim would fail. Accordingly, her state-law claim, like Davila's, depends on a showing that she was entitled to payment under her ERISA plan for the additional medical treatment she sought. It follows that Calad's complaint, like Davila's, is subject to removal under the complete preemption doctrine.

c. These cases differ from *Pilot Life* and *Taylor* in that the benefits involved here are health care benefits, rather than disability benefits, and the defendants here are HMOs, rather than traditional insurers. Those facts, however, have no bearing on the analysis. Congress "expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants * * * asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." *Pilot Life*, 481 U.S. at 52; see *Taylor*, 481 U.S. 63. That rationale applies regardless of whether the defendant is a traditional insurer making a post-treatment coverage decision under a fee-for-services plan (as in *Pilot Life* and *Taylor*) or an HMO making a pre-certifica-

tion coverage decision (as here), and regardless of whether the claims involve disability benefits (as in *Pilot Life* and *Taylor*) or medical benefits (as here). Accordingly, the rationale of *Pilot Life* and *Taylor* applies here, and respondents' claims are completely preempted.[3]

3. If any doubt remained as to whether respondents' state law claims fall within the scope of Section 502(a)(1)(B) of ERISA, the ability of claimants who are similarly situated to respondents to sue under ERISA confirms that respondents' claims are completely preempted. As the Third Circuit noted in holding that ERISA completely preempted a state-law claim against an HMO for denying treatment by an out-of-network provider, "[t]here have been numerous cases in which [federal] courts have issued preliminary injunctions under similar circumstances." *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001).[4] There are also

[3] By requiring that claims challenging HMO coverage decisions be brought under Section 502(a)(1)(B), the complete preemption doctrine ensures that ERISA standards—including the federal common law that Congress expected would apply to benefit claims, see *Pilot Life*, 481 U.S. at 56—will continue to apply to HMO coverage decisions in the same way they apply to coverage decisions by traditional insurers, such as Blue Cross and Blue Shield, and companies that administer self-insured plans. See, *e.g.*, *Kopicki* v. *Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467, 470 (D. Md. 2000) (pre-treatment coverage decision by company administering self-insured plan); *Kekis* v. *Blue Cross & Blue Shield of Utica-Watertown, Inc.*, 815 F. Supp. 571, 573-576 (N.D.N.Y. 1993) (pre-treatment coverage decision by Blue Cross/Blue Shield).

[4] See, *e.g.*, *Heasley* v. *Belden & Blake Corp.*, 2 F.3d 1249, 1253 (3d Cir. 1993) (participant's challenge to administrator's decision not to pre-authorize liver transplant); *Kopicki* v. *Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d at 470-471 (beneficiary's challenge to administrator's decision not to pre-authorize stem cell treatment for cancer); *Marro* v. *K-III Communications Corp.*, 943 F. Supp. 247, 248-249 (E.D.N.Y. 1996) (similar); *Mattive* v. *Healthsource of Savannah, Inc.*, 893 F. Supp. 1559, 1562-1563 (S.D. Ga. 1995) (similar); *Kekis*, 815 F. Supp. at 576-577 (similar); *Wilson* v. *Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309, 310 (D.D.C. 1992) (similar), appeal dismissed, 995 F.2d 306 (D.C. Cir. 1993); *Kulakowski* v. *Rochester Hosp. Serv. Corp.*, 779 F. Supp. 710, 711-712 (W.D.N.Y. 1991) (similar); *White* v. *Caterpillar, Inc.*, 765 F. Supp. 1418, 1419-1420 (W.D. Mo.) (similar), aff'd, 985 F.2d 564 (8th Cir. 1991).

cases in which a claimant obtains treatment recommended by a treating physician despite a refusal by a managed care entity to pay for it, and later challenges the HMO's denial of benefits under ERISA. See, *e.g.*, *Shannon* v. *Jack Eckerd Corp.*, 113 F.3d 208, 209 (11th Cir. 1997), cert. denied, 522 U.S. 1111 (1998); United States General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* 12 (July 1998) (GAO/HEHS-98-154) (*GAO Report*) ("A health plan's decision to deny coverage does not preclude the attending physician from providing treatment—if the patient can obtain other funding to pay for it."); 02-1845 Pet. App. 177a; 03-83 Pet. App. 34a-35a. The fact that Section 502(a)(1)(B) provides remedies for the precise types of wrongs respondents allege confirms that respondents' state-law claims fall within the scope of that provision and are therefore completely preempted.[5]

C. The Fact That Plaintiffs' Actions Are Tort-Based Underscores Their Complete Preemption

1. The court of appeals held that respondents' claims are not completely preempted—indeed, are not preempted at all —because the fact that they are tort-based makes their "claims of HMO medical malpractice differ fundamentally

[5] If, contrary to our argument, respondents' state-court actions fell outside the scope of Section 502(a)(1)(B), they may nevertheless be completely preempted because they would fall within the scope of Section 502(a)(3) of ERISA, 29 U.S.C. 1132(a)(3). Section 502(a)(3) allows a participant or beneficiary to sue to enjoin a violation of ERISA or of the plan, or to obtain "other appropriate equitable relief" to redress such a violation or to enforce any provisions of ERISA or the plan. 29 U.S.C. 1132(a)(3). Section 502(a)(3) thus allows participants and beneficiaries to obtain individual relief for a breach of a fiduciary obligation. *Varity Corp.* v. *Howe*, 516 U.S. 489, 507-515 (1996). See also note 13, *infra*.

from * * * § 502(a)(1)(B) claims." 02-1845 Pet. App. 16a. The court reasoned that "Section 502(a)(1)(B) * * * creates a cause of action for breach of contract," while respondents "assert tort claims." *Ibid.* The court went on to emphasize the remedies sought and noted that "Calad is not requesting the value of an extra night at the hospital, and Davila is not requesting reimbursement for the more expensive drug the HMO denied." *Id.* at 17a. Because respondents "are not seeking reimbursement for benefits denied them," *ibid.*, the court concluded that their claims are not preempted or completely preempted by Section 502(a)(1)(B).

The court's conclusion is inconsistent with *Pilot Life*, *Taylor*, and *Ingersoll-Rand*, each of which involved claims that were directly pleaded as tort or tort-like claims and each of which involved claims for damages that extended beyond the benefits or rights due.[6] In each of those cases, the Court held that the plaintiff's claims were preempted, and nothing in the Court's analysis or result suggested that the label placed upon the plaintiff's claim in those cases—whether contract, tort, or some mixture of the two—had any relevance at all to the question. "Any other result would elevate form over substance and allow parties to evade the requirements of [the federal statute] by relabeling their contract claims as claims for tortious breach of contract."

[6] See *Pilot Life*, 481 U.S. at 43 (plaintiff pled claims for "Tortious Breach of Contract," "Breach of Fiduciary Duties," and "Fraud in the Inducement," and sought compensatory and punitive damages); *Taylor*, 481 U.S. at 61, 62 (noting that plaintiff sought "compensation for mental anguish caused by breach of * * * contract" and holding that plaintiff's "common law contract and tort claims are pre-empted by ERISA"); *Ingersoll-Rand*, 498 U.S. at 136 (Plaintiff "sought compensatory and punitive damages under various tort and contract theories."); see also *Rush*, 536 U.S. at 377 ("In *Pilot Life*, an ERISA plan participant who had been denied benefits sued in a state court on state tort and contract claims."); *id.* at 379 (noting that in *Ingersoll-Rand*, the court "had no trouble finding that Texas's tort of wrongful discharge * * * conflicted with ERISA enforcement").

Allis-Chalmers Corp. v. *Lueck*, 471 U.S. 202, 211 (1985) (holding that complete preemption under Section 301 of the LMRA, which provides for enforcement of contract rights under a collective bargaining agreement, applies to state-law tort claims). Indeed, the fact that the state-law claims provide additional tort-based remedies rather than merely duplicating the remedies typically available under Section 502(a)(1)(B) only underscores the rationale for finding those claims preempted. Although the labels placed on the plaintiffs' claims in *Pilot Life* and subsequent cases thus had no significance, the fact that the plaintiffs in those cases sought tort-like remedies that extended beyond those authorized in Section 502(a)(1)(B) was at the heart of the Court's conclusion that the claims conflicted with Congress's tailoring of remedies in ERISA and therefore were preempted or completely preempted.

2. The court of appeals recognized that *Pilot Life* "includes some expansive language" that "arguably supports" complete preemption, 02-1845 Pet. App. 19a, but the court believed that this Court's more recent decision in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), "indicates that *Pilot Life* does not sweep so broadly." As support for that contention, the court of appeals noted that this Court in *Rush* had characterized *Ingersoll-Rand* as a case in which the "state law duplicated the elements of a claim available under ERISA" and had stated that the state law thus "converted the remedy from an equitable one under § 1132(a)(3) * * * into a legal one for money damages." 02-1845 Pet. App. 19a-20a (quoting *Rush*, 536 U.S. at 379). In the court of appeals' view, that reference in *Rush* generated a rule that "the test employed for 'complete preemption'" is that "States may not duplicate the causes of action listed in ERISA § 502(a)." *Id.* at 20a.

The court of appeals' reasoning is faulty. Nothing in *Rush* suggests that complete preemption is *limited* to such cases

of "duplication." And in any event, the sense in which the claim in *Ingersoll-Rand* "duplicated" the ERISA cause of action is identical to the sense in which the claims in *Pilot Life*, *Taylor*, and this case do. As explained above, the plaintiff's claim in each case "duplicate[s]" an ERISA claim because it cannot succeed without essentially proving the elements of an ERISA claim. The fact that the plaintiffs in *Ingersoll-Rand* and other cases prior to *Rush* might have had to prove *additional* facts or elements beyond those required by Section 502(a)(1)(B) or Section 502(a)(3) to obtain the additional forms of recovery they sought under state law did not prevent preemption of the state-law claims. It is typically true that a plaintiff seeking to recover compensatory or punitive damages must prove facts beyond those necessary to establish a violation of a substantive duty by the defendant. That aspect of the cases therefore was of no significance. What was significant was that, with respect to claims that required proof of the essential elements of an ERISA claim, state law provided for remedies beyond those available under ERISA, thus making the preemption of the state law particularly clear. See *Pilot Life*, 481 U.S. at 54-57; *Taylor*, 481 U.S. at 63, 64-65; *Ingersoll-Rand*, 498 U.S. at 144-145. Similarly here, the fact that respondents would have to prove additional facts or elements to obtain the compensatory and punitive damages they seek—remedies not available under Section 502(a)(1)(B)—does not prevent preemption of their state-law claims.

Far from casting doubt on those earlier precedents, this Court's decision in *Rush* relied upon and reinforced them. The Court emphasized that the state statute providing for independent review of HMO medical necessity determinations in that case "provides no new cause of action under state law and authorizes no new form of ultimate relief." 536 U.S. at 379. Because "the relief ultimately available [after the independent review] would still be what ERISA author-

izes in a suit for benefits under § 1132(a)," the Court explained that *Rush* "does not involve the sort of additional claim or remedy exemplified in *Pilot Life* [and] *Ingersoll-Rand*." *Id.* at 380. On that basis, the Court held that the state-law independent-review scheme did not fall within *Pilot Life*'s rule of categorical preemption. *Ibid.* In this case, by contrast, respondents plainly do seek remedies beyond those provided by Section 502(a)(1)(B). Accordingly, the Court's reasoning in *Rush* supports and reaffirms the conclusion that under *Pilot Life*, *Taylor*, and *Ingersoll-Rand*, respondents' claims are completely preempted.

D. *Pegram* v. *Herdrich* Does Not Bar Complete Preemption Of Respondents' Claims

The court of appeals suggested briefly that this Court's concern in *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), that "ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice" supports its conclusion that the state-law claims in this case are not completely preempted. 02-1845 Pet. App. 20a; see also *Cicio* v. *Does*, 321 F.3d 83, 100-104 (2d Cir. 2003), petition for cert. filed, No. 03-69 (July 11, 2003). That suggestion is mistaken.[7]

1. In *Pegram*, an ERISA plan participant contended that an HMO had violated its fiduciary duties under ERISA by structuring its operations so that its physician-owners re-

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[7] The court of appeals relied more extensively on *Pegram* for its conclusion that the claims here are not preempted by Section 502(a)(2) of ERISA, 29 U.S.C. 1132(a)(2). 02-1845 Pet. App. 12a-15a. That provision does not preempt respondents' actions for reasons independent of *Pegram*. Section 502(a)(2) allows a participant or beneficiary to sue a fiduciary for "appropriate relief" under Section 409 of ERISA, 29 U.S.C. 1109, including "removal of [a breaching] fiduciary," 29 U.S.C. 1109(a). Section 502(a)(2), however, provides relief to the plan, rather than to individuals. *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 140 (1985). Because the claimants here seek only individual relief, their claims do not fall within the scope of Section 502(a)(2).

ceived greater profits if they held down the HMO's medical treatment expenses. The plaintiff alleged that the plan's physicians acted in a fiduciary capacity when they made "mixed eligibility and treatment decisions," 530 U.S. at 229 —decisions that mix questions concerning "the plan's coverage of a particular condition or medical procedure for its treatment" with "choices about how to go about diagnosing and treating a patient's condition," *id.* at 228. This Court held that "mixed eligibility [and treatment] decisions by HMO physicians are not fiduciary decisions" that are subject to suit under Section 502(a)(2) for breach of a fiduciary duty under ERISA. *Id.* at 237.

2. *Pegram* is inapposite here. Even if HMO coverage decisions by a *non*-treating physician were "mixed" eligibility and treatment decisions under *Pegram* (but see pp. 23-25, *infra*), there would be no reason for the Court to read *Pegram* to foreclose complete preemption of respondents' state-law claims. The Court in *Pegram* stated that it was not addressing preemption issues. See 530 U.S. at 229 n.9. Moreover, this case does not turn on whether any particular decision was or was not a fiduciary decision under ERISA. It does not matter in this case whether the HMO representatives who decided not to pay for respondents' requested medical treatment made a fiduciary decision under ERISA or a "mixed" eligibility and treatment decision that was not a fiduciary act under *Pegram*. In either event, the state-law actions brought by respondents fall within the scope of Section 502(a)(1)(B) and seek to add to ERISA's remedies by permitting a plan participant to recover damages, including punitive damages, for a denial of benefits. A wrongful denial of benefits is actionable under Section 502(a)(1)(B) regardless of whether it constitutes a fiduciary breach. Accordingly, those state-law actions fall within the scope of Section 502(a)(1)(B), and are removable to federal court, regardless

of the fiduciary or non-fiduciary nature of the decisions attacked by respondents.

3. In any event, as the government pointed out in its brief as amicus curiae in *Rush*, *Pegram*'s holding that "mixed eligibility [and treatment] decisions by HMO physicians are not fiduciary decisions" under ERISA, 530 U.S. at 237, should not be extended beyond decisions made by treating physicians who are also making HMO eligibility decisions. See U.S. Br. at 7-11, *Rush*, *supra* (No. 00-1021). Although some statements in *Pegram*, if read in isolation, might suggest a broader application of the "non-fiduciary" rule, the better reading of *Pegram* is that it addresses only mixed decisions made by treating physicians.[8]

That limitation of *Pegram* to treating physicians serving dual roles makes sense. When the same doctor decides both treatment and eligibility questions, as may occur in a staff-model HMO, the treatment decision truly is "practically inextricable" from the eligibility decision. In HMOs such as those in this case, however, the treatment and coverage questions are separate, with a contract physician deciding the appropriate treatment and the HMO independently deciding whether to pay for it. The coverage decision may, as in *Pegram*, turn on a determination of medical necessity, but

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[8] The plaintiff's claim in *Pegram* grew out of a decision made by her treating physician, see 530 U.S. at 215, 217, 231, and there is no indication that she then sought review through the plan's appeal process. Furthermore, although the Court in *Pegram* did not regard the plaintiff's claim of fiduciary breach as limited to a single incident of poor treatment, see *id.* at 226, the Court did appear to view her claim as involving only an attack on the compensation policies as they affected treating physicians. See, *e.g.*, *id.* at 228 (noting that treatment and eligibility decisions are "practically inextricable from one another * * * not merely because" they are "made by the same person, the *treating physician*," but also "because a great many * * * coverage questions are not simple yes-or-no questions") (emphasis added); *id.* at 232 ("physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day").

in the end it is a decision on whether the HMO will pay under the terms of the plan, not whether the physician may provide the recommended treatment anyway (with some other source of funds) outside the plan. See *GAO Report* 12 (a health plan's decision to deny coverage does not preclude the attending physician from providing treatment if the patient can pay for it). Under the *Pegram* categorization, therefore, the HMO's decision is an "eligibility" determination that is subject to ERISA fiduciary duty standards, not a "mixed" decision outside those standards.

Pegram also must be read against the background of provisions of ERISA itself and longstanding Labor Department regulations and interpretations that provide that plan administrators who make coverage decisions on review of the denials of claims for benefits *are* plan fiduciaries. Whatever else HMOs do to provide health care to the participants and beneficiaries of an ERISA plan they service, acting as the entity that determines eligibility for plan benefits in a given case is at the core of what HMOs do.[9] ERISA makes clear that an entity responsible for that determination must be an ERISA fiduciary. See 29 U.S.C. 1002(21)(A)(iii) (a fiduciary includes a person to the extent "he has any discretionary authority or discretionary responsibility in the administration of such plan"); *Varity Corp.*, 516 U.S. at 511 ("a plan

[9] See *Pegram*, 530 U.S. at 219 (citations omitted):

> At the least, HMOs, like traditional insurers, will in some fashion make coverage determinations, scrutinizing requested services against the contractual provisions to make sure that a request for care falls within the scope of covered circumstances (pregnancy, for example), or that a given treatment falls within the scope of the care promised (surgery, for instance). They customarily issue general guidelines for their physicians about appropriate levels of care. * * * And they commonly require utilization review (in which specific treatment decisions are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment.

administrator engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents"); accord *id.* at 530 (Thomas, J., dissenting).[10] Construing *Pegram* to mean that HMO representatives are not ERISA fiduciaries when they decide on behalf of the plan whether to pay for treatment that a primary care physician recommends would thus conflict with the statutory and administrative framework for claims adjudication generally.

E. Complete Preemption Effectuates The Congressional Balance Between Providing Prompt And Appropriate Remedies For Claimants And Encouraging The Formation And Growth of Employee Benefit Plans

ERISA does not provide the full range of remedies available under state tort law and does not provide at all for punitive damages. In some circumstances, moreover, a denial of coverage by an HMO may result in a denial of treatment—if time constraints effectively preclude a suit for injunctive relief under ERISA and the claimant cannot afford to pay for treatment from other funds and then later seek recovery from the HMO. Those features of ERISA's enforcement scheme, however, do not mean that this Court should refuse to apply the complete preemption doctrine to HMO coverage decisions that may in turn have an effect on a claimant's

[10] See also 29 U.S.C. 1133(2) ("[i]n accordance with regulations of the Secretary [of Labor], every employee benefit plan shall * * * afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review *by the appropriate named fiduciary* of the decision denying the claim") (emphasis added). Section 503(2) also requires ERISA plans to decide claims "[i]n accordance with regulations of the Secretary." 29 U.S.C. 1133(2). The Secretary has made clear that claimants must have an opportunity to appeal "an adverse benefit determination *to an appropriate named fiduciary.*" 29 C.F.R. 2560.503-1(h)(1) (emphasis added); see also 29 C.F.R. 2560.503-1(h)(3)(ii) and (i)(1)(ii)); 29 C.F.R. 2560.503-1(g)(1) (2000) (superseded regulation, requiring appeal to fiduciary or person designated by the fiduciary).

ability to obtain medical treatment. Such a refusal would upset the balance reflected in ERISA's civil enforcement provisions between providing prompt and appropriate remedies for claimants and encouraging the formation and growth of employee benefit plans.

1. In enacting ERISA, Congress intended generally to promote the interests of participants and beneficiaries in employee benefit plans, 29 U.S.C. 1001(b), but Congress stopped short of requiring employers to establish such plans. *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). Congress also did not require employers that offer plans to "provide any particular benefits." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).[11] Accordingly, the "'comprehensive civil enforcement scheme'" in Section 502(a) of ERISA, 29 U.S.C. 1132(a), "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Ingersoll-Rand*, 498 U.S. at 144 (quoting *Pilot Life*, 481 U.S. at 54).

The balance Congress struck provides effective remedies for most claimants who promptly and properly seek them.[12]

[11] One of the very few exceptions is 29 U.S.C. 1185(a), which requires group health plans and health insurance issuers to provide at least 48 hours of hospitalization after childbirth, if they offer maternity benefits. ERISA does not require minimum periods of hospitalization for other benefits a plan chooses to provide, such as coverage for respondent Calad's hysterectomy.

[12] HMOs must provide claimants with "full and fair review" of a denial of a claim for benefits. 29 U.S.C. 1133(2); 29 C.F.R. 2560.503-1(h)(1). Such review must "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. 2560.503-l(h)(2)(iv). The plan administrator's decision must also provide the "specific reasons" for any adverse determination (29 U.S.C. 1133(1); 29 C.F.R. 2560.503-l(g)(1)(i) and (j)(1)), and the claimant must be furnished, or afforded the right to obtain, an "explanation of the scientific or clinical judgment" for certain determinations by group health and disability plans. 29 C.F.R. 2560.503-l(j)(5)(ii). See generally U.S. Amicus Br.

First, under Section 502(a)(1)(B), Congress has allowed claimants to sue not just for benefits that are due, but also to enforce their rights under the plan and clarify rights to future benefits. 29 U.S.C. 1132(a)(1)(B). Thus, a claimant may bring an action under Section 502(a)(1)(B) to challenge a pre-treatment denial of coverage by asking a court to order a managed care company (or other entity that administers a health plan) to pay for proposed treatment. See note 4, *supra*. Successful claimants may be awarded attorneys' fees. See 29 U.S.C. 1132(g). District courts have been able to act quickly to provide relief to such claimants when necessary. See, *e.g.*, *Wilson* v. *Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309, 310 (D.D.C. 1992) (April 13, 1992 temporary restraining order prevented insurer from refusing to pay for April 14, 1992 treatment), appeal dismissed, 995 F.2d 306 (D.C. Cir. 1993); *White* v. *Caterpillar, Inc.*, 765 F. Supp. 1418, 1418-1419 (W.D. Mo.) (action brought June 13, 1991; preliminary injunction issued June 26, 1991), aff'd, 985 F.2d 564 (8th Cir. 1991). Further remedies may also be available under Section 502(a)(3) of ERISA, which provides, *inter alia*, for "appropriate equitable relief" to "redress" violations of ERISA (including its fiduciary-duty provisions, see *Varity Corp.*, 516 U.S. at 507-515) or of an ERISA plan.[13]

at 8-11, 15-17, *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822 (2003) (No. 02-469).

[13] Although this Court has construed Section 502(a)(3) not to authorize an award of money damages against a non-fiduciary, it has also recognized that the "equitable relief" authorized by Section 502(a)(3) means relief typically available in equity. See *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 210, 217 (2002); *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 248-250, 256-258 (1993). Neither *Great-West* nor *Mertens* involved actions against a fiduciary. After *Great-West*, the government has taken the position in several cases pending in the courts of appeals that Section 502(a)(3) allows at least some forms of "make-whole" relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench. See generally Sec'y of Labor Amicus Br. at 19-23, *Mathews* v. *Chevron Corp.*, Nos. 02-15936 & 02-16209

Second, Congress required plans to establish a claims procedure in accordance with regulations of the Secretary of Labor. 29 U.S.C. 1133. The Department of Labor's new claims regulations, applicable to plan years beginning July 1, 2002, see 66 Fed. Reg. 35,886 (2001), specifically address managed care decision-making by including short time frames for a group health plan's decisions on claims. See 29 C.F.R. 2560.503-1(f)(2)(i) (decision no later than 72 hours after receipt of claim for urgent care claims); 29 C.F.R. 2560.503-1(f)(2)(iii)(A) (not later than 15 days for a pre-service claim, subject to one extension for matters beyond plan's control). Those new regulations may reduce the need for and incidence of court challenges. See *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266, 275 (3d Cir. 2001).

Third, States may provide for an independent review of HMO medical necessity decisions. *Rush*, 536 U.S. at 359-360.

(9th Cir. filed Nov. 25, 2002). Historically, a beneficiary's claim against a trustee for a breach of trust was typically remedied *exclusively* in the courts of equity because the beneficiary had only an equitable, not a legal interest, in the trust and its assets. See Restatement (Second) of the Law of Trusts §§ 2 cmts. e and f, 197 (1959). A beneficiary therefore could maintain a suit in equity to obtain various forms of relief, including to compel the trustee to perform his duties as trustee, to enjoin the trustee from committing a breach, and "to compel the trustee to redress a breach of trust." *Id.* § 199(a)-(c). The trustee's liability in the event of a breach gave rise to various alternative remedies, including a remedy that "will put [the beneficiary] in the position in which he would have been if the trustee had not committed the breach of trust." *Id.* § 205 & cmt. a. A monetary recovery in those circumstances did not require a showing of unjust enrichment. See, *e.g.*, *id.* § 205, cmt. c; *Strom* v. *Goldman, Sachs & Co.*, 202 F.3d 138 (2d Cir. 1999); *Bowerman* v. *Wal-Mart Stores, Inc.*, 226 F.3d 574 (7th Cir. 2000); see generally George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* 861, at 3-4 (rev. 2d ed. 1995). Neither *Great-West* nor *Mertens* supports the proposition that Congress intended that the courts should ignore that settled trust-law understanding dating from the days of the divided bench. There is no occasion for the Court to address that issue here. Judicial acceptance of this position would, however, provide an effective remedy in many cases where the remedy under Section 502(a)(1)(B) may be inadequate.

Such review also decreases the chances that a claimant will be harmed by an erroneous HMO coverage decision. See *GAO Report* 24 (external review procedure "could resolve disputes before harm occurred and could prevent the need for lawsuits later on"); Gail B. Agrawal & Mark A. Hall, *What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 St. Louis U. L.J. 235, 278 (2003)).

Finally, claimants may also sue their treating physicians for malpractice if the physicians' actions of commission or omission fall below the standards set for appropriate medical care. See, *e.g.*, *Pryzbowski*, 245 F.3d at 279. Courts have also held that HMOs may be sued under state law, without preemption by ERISA, when they are vicariously liable for a treating physician's decisions. See, *e.g.*, *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999), cert. denied, 530 U.S. 1242 (2000); *Villazon* v. *Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 851-854 (Fla. 2003). In addition, HMOs like petitioner Aetna and CIGNA in this case have an incentive to inform participants clearly that they provide only coverage, not treatment, and that an HMO determination not to provide coverage does not preclude claimants from obtaining care recommended by a treating physician through other sources of funds.

2. Failing to find preemption of state remedies would "completely undermine[]" Congress's decision to include certain remedies and exclude others under ERISA itself. *Ingersoll-Rand*, 498 U.S. at 144 (quoting *Pilot Life*, 481 U.S. at 54). As employers have noted, imposition of liability under state law could prevent employers from designing innovative health plans that are consistent across state borders and could make employers less willing to provide health benefits because of the higher costs associated with them. *GAO Report* 22; see also *id.* at 27. That result would

frustrate ERISA's broader goal of promoting the interests of participants and beneficiaries.

Indeed, permitting such suits against HMOs that provide health care through ERISA plans could easily lead to large punitive damage awards—something that ERISA itself, with its tailored remedies, does not allow. See *Dardinger* v. *Anthem Blue Cross & Blue Shield*, 781 N.E.2d 121, 140-145 (Ohio 2002) ($30 million punitive damage award); Gail B. Agrawal & Mark A. Hall, *supra*, 47 St. Louis U. L.J. at 240 n.16 (reporting punitive damage awards of $77 million and $120 million, and an award of $80 million that was set aside on appeal for improper jury instructions and evidentiary errors). There is nothing in ERISA or in this Court's precedents that requires such a result.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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DECEMBER 2003

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* The Solicitor General is recused in this case.

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IN THE

Supreme Court of the United States

AETNA HEALTH, INC.
Petitioner,

v.

JUAN DAVILA
Respondent.

CIGNA HEALTHCARE OF TEXAS, INC., AND
CIGNA CORPORATION
Petitioner,

v.

RUBY R. CALAD, *et al.*
Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR AAHP-HIAA, THE BLUE CROSS BLUE SHIELD ASSOCIATION, AND THE AMERICAN BENEFITS COUNCIL AS AMICI CURIAE SUPPORTING PETITIONERS

STEPHANIE W. KANWIT
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In the Supreme Court of the United States

Nos. 02-1845 & 03-83

AETNA HEALTH, INC.
Petitioner,

v.

JUAN DAVILA
Respondent.

CIGNA HEALTHCARE OF TEXAS, INC., AND CIGNA CORPORATION
Petitioner,

v.

RUBY R. CALAD, *et al.*
Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR AAHP-HIAA, THE BLUE CROSS BLUE SHIELD ASSOCIATION, AND THE AMERICAN BENEFITS COUNCIL AS AMICI CURIAE SUPPORTING PETITIONERS

The American Association Of Health Plans-Health Insurance Association Of America, Inc., The BlueCross BlueShield Association, and The American Benefits Council respectfully submit this brief as amici curiae supporting petitioners.[1]

[1] This brief was prepared in its entirety by amici and their counsel. No monetary contribution toward the preparation or submission of this brief was made by any person other than amici, their members, and their counsel. Petitioners and respondents have consented to the filing of this brief in letters filed with the Clerk.

event, and a doctor, hospital, or pharmacy is free to provide it--just as would be true under a traditional, fee-for-service plan. The pre-approval process, however, protects both beneficiaries and providers from incurring expenses based on an unjustified expectation that a third-party payor will agree that those expenses fall within its reimbursement obligations.

C. The Quality Of Care Delivered Through MCO Plans Equals Or Exceeds The Quality Of Care Delivered Through Fee-For-Service Plans

As should be evident, there is no reason to expect that benefits-management techniques of the sort at issue here would adversely affect the quality of care received by plan beneficiaries, as compared to traditional indemnity plans. And, indeed, a large body of empirical evidence demonstrates that although managed-care organizations cover care at significantly lower cost than more traditional plans,[12] that care is of the same, or even higher, quality. In fact, health plans have been measuring and publicly reporting results on select quality measures for nearly a decade.

One recent study, for example, examined the occurrence of preventable hospitalizations in populations enrolled in managed-care and fee-for-service plans. By that measure, the quality of care delivered to enrollees of MCOs equaled or exceeded that of the care delivered to enrollees of fee-for-service plans with respect to four of the five medical conditions studied.[13] Other studies have concluded that, for example:

[12] Dean G. Smith, *The Effects of Preferred Provider Organizations on Health Care Use and Costs*, Inquiry, Winter 1997/1998, at 278, 282 (U. Mich. School of Public Health study funded by the Robert Wood Johnson Foundation) (PPOs saved 12% per covered life per year when compared to a traditional indemnity plan with utilization review).

[13] L. Clark Paramore & Anne Clixhauser, *Assessments of Quality of Care for Managed Care and Fee-for-Service Patients Based on Analysis of Avoidable Hospitalizations*, 2 Value in Health 258 (1999).

- All indicators of timeliness and quality of care for Medicare heart attack patients were similar or higher for patients enrolled in HMOs compared to patients receiving FFS coverage. Patients enrolled in HMOs were significantly more likely than patients receiving FFS coverage to receive aspirin and beta-blocker therapy after heart attacks.[14]
- Angina patients enrolled in MCOs were likely to receive similar or better care, and were much more likely to be released from the hospital on guideline-recommended medications, than patients in FFS plans.[15]
- Patients enrolled in commercial HMOs who were hospitalized with congestive heart failure had the same or better quality of care as, and lower mortality rates than, those enrolled in commercial FFS plans.[16]
- Medicare HMO enrollees were more likely to have breast cancer diagnosed before the later stages of the disease, to receive breast-conserving surgery, and to obtain recommended radiation therapy than Medicare FFS enrollees.[17] Breast-cancer patients had at

[14] Stephen B. Soumerai et al., *Timeliness and Quality of Care for Elderly Patients with Acute Myocardial Infarction Under HMO vs. Fee-for-Service Insurance*, 159 Archives Internal Med. 2013, 2017-2018 & fig. (1999).

[15] Nathan R. Every et al., *Influence of Insurance Type on the Use of Procedures, Medications, and Hospital Outcome in Patients with Unstable Angina: Results From the GUARANTEE Registry*, 32 J. of Am. Coll. of Cardiology 387 (1998).

[16] Edward F. Philbin et al., *Managed Care for Congestive Heart Failure: Influence of Payer Status on Process of Care, Resource Utilization, and Short-term Outcomes*, Am. Heart J., Sept. 1998, at 553.

[17] Gerald F. Riley et al., *Stage at Diagnosis and Treatment Patterns Among Older Women with Breast Cancer: An HMO and Fee-for-Service Comparison*, 281 JAMA 720 (1999).

INTERESTS OF AMICI

The American Association Of Health Plans-Health Insurance Association Of America, Inc. (AAHP-HIAA) is the national association representing the private health plan and insurer community. AAHP-HIAA's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to its members. AAHP-HIAA represents nearly 1,300 member companies that administer or insure benefits, including health, pharmaceutical, long-term care, disability, and supplemental coverage, to more than 200 million Americans, the majority of whom are participants in or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

The BlueCross BlueShield Association comprises 41 independent, locally operated BlueCross and BlueShield Plans. The BlueCross and BlueShield companies provide, through relationships with employers, employee benefits plans, and direct contracts with subscribers, health insurance to private and public employees and individuals, including fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the BlueCross and BlueShield companies furnish health care coverage to 88.6 million—or one in four—Americans, making them (as a group) the largest U.S. entity offering health insurance and benefits.

The American Benefits Council is a broad-based, nonprofit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively,

its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

SUMMARY OF ARGUMENT

Since 1974, ERISA's establishment of a uniform system for regulating employee benefit plans has fostered the development of widespread, voluntary, employment-based health care coverage. Under that system, employers and unions have taken up the challenge of sponsoring health benefit plans to provide employees and other beneficiaries with substantial financial protection from the high cost of health care. This private benefits system, in which specific terms of coverage are chosen by particular sponsors, as appropriate for their resources and the needs of a given group, has allowed the development of a wide variety of specific benefit plans. Voluntary, employment-based plans now provide coverage for many health care costs for over 130 million individuals in the United States.

All such plans ultimately reflect the sponsors' and participants' shared interest in obtaining the best possible coverage that can be provided at a sustainable cost. The cost portion of this equation presents particular challenges, because of the special features of the health-care marketplace. Responding to economic challenges such as steep increases in the cost of hospital care and prescription drugs, both public and private health benefit administrators have developed an array of techniques for ensuring the cost-effectiveness of the benefits they provide. These techniques, generally grouped under the term "managed care," are not concerned with what care a beneficiary may or may not choose and be able to procure with individual resources. They address instead what measures the party that is administering the group plan will recognize (and, indeed, sometimes encourage) as cost-justified. Such determinations go to the heart of the administrator's obligation to manage limited funds prudently on behalf of *all* the beneficiaries who will need to draw on its resources, in accordance with the contractually specified terms of the plan.

It is important to recognize that evidence-based coverage guidelines and similar benefit-management techniques may promote, as well as restrain, the use of benefits to pay for care that is medically appropriate—and the need for which might or might not be recognized or pursued under traditional, fee-for-service coverage. This reflects the fact that the interests of plan sponsors, beneficiaries, and administrators are all well served when evidence-based techniques ensure that a plan's resources are used to pay justified amounts for care that is likely to be genuinely beneficial. To that end, as well, plans provide internal mechanisms for establishing exceptions to general guidelines, and for the rapid review of initial coverage-management decisions. There are also options for external review, including appeal to the courts under ERISA. Finally, in important respects the sort of decisions made under coverage-management provisions do not differ in kind from the "medical necessity" determinations that have always been required for insurance coverage under any sort of plan: They are simply more structured, and better timed. Pre-utilization review of coverage protects both beneficiaries and health-care providers from incurring expenses based on an unjustified expectation that a third-party payor will agree that those expenses fall within its reimbursement obligations.

For these reasons, one would not expect coverage-management techniques of the sort at issue in these cases to adversely affect the quality of care provided to plan beneficiaries, as compared to traditional indemnity insurance plans. Indeed, empirical studies confirm that although managed-care organizations (MCOs) administer medical benefits at significantly lower cost than more traditional insurance, beneficiaries covered by MCOs receive care of the same or even higher quality.

Although it has succeeded in providing high-quality health coverage for millions of Americans, the employment-based coverage system fostered by ERISA is under severe strain from rapidly increasing health care costs—in particular, the sorts of prescription drug and hospitalization costs

that are implicated in these cases. Particularly in light of these pressures, the Fifth Circuit was wrong to adopt an interpretation of federal law that would permit state tort suits based on plans' coverage decisions. There is no reason to believe that such suits are necessary to protect plan beneficiaries, or in particular to supplement the carefully selected, nationally uniform remedies already provided by Congress in ERISA. To the contrary, allowing state suits would be affirmatively harmful. By increasing complexity, reducing predictability, and otherwise increasing costs, such suits would undermine precisely the uniformity and efficiency that Congress sought to foster in ERISA. The response of plan sponsors is not hard to predict: Some will restrict benefits, including replacing discretionary decisions with categorical exclusions, or further increase direct employee costs. Others may simply discontinue, or decline to institute, health benefits. Either way, allowing state suits would significantly undermine Congress's goal of encouraging employment-based health coverage, without promising any counter-balancing increase in protection for those individuals who remain covered by ERISA plans.

ARGUMENT

I. VOLUNTARY EMPLOYEE HEALTH BENEFIT PLANS, SPONSORED BY EMPLOYERS AND SUBJECT TO UNIFORM FEDERAL REGULATION UNDER ERISA, ARE THE FOUNDATION OF THE NATION'S HEALTH COVERAGE SYSTEM

One significant challenge for contemporary societies is providing widespread access to high-quality health care, at a sustainable cost. In the United States this goal has been pursued largely—and very successfully—through the mechanism of voluntary health benefit plans that are sponsored by employers (including federal and state governments) or unions, and provide coverage to groups of employees.

This system takes advantage of private interests and mechanisms to produce a system that is both robust and flexible. Plan sponsors have a strong interest in providing

employees with high-quality health coverage, both as a form of compensation and because such coverage leads to higher productivity. Employees have a strong interest in obtaining coverage, and in benefiting from the efficiencies made possible by group plans. Sponsors and employees together bear the cost of coverage, and thus have a mutual interest in the availability of plans that provide the mixture of comprehensiveness and affordability that is most appropriate for their particular circumstances. Finally, health insurers and benefit administrators have strong incentives to satisfy these demands by providing sponsors and employees with a wide variety of potential plans, all of which will seek to provide covered individuals with the most attractive possible combinations of coverage and price.

For 30 years, ERISA has encouraged and protected the development of this privately-ordered approach to health care coverage. "Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). Rather, the Act enables and facilitates the voluntary establishment of plans, on whatever terms are chosen by particular sponsors and groups of employees.

One principal way it does this is by protecting plan sponsors, which frequently have employees and operations in many States, from the burdens of having to comply with multiple regulatory regimes. In framing ERISA, Congress recognized that while some regulation was necessary, the overall costs of compliance would inevitably affect whether plans would be established, and what level of actual benefits they could provide. Because inefficiency in regulation would ultimately hurt actual or prospective plan participants, Congress concluded that "employee benefit plans would prosper best if regulated by the federal government without

state involvement."[2] Accordingly, "[o]ne of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001) (internal quotation marks and citation omitted). "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Id.* The exclusive remedy provisions at issue in these cases, which protect plan administrators against state-law challenges to their individual coverage determinations outside the carefully balanced remedial framework provided by ERISA itself, are of central importance in maintaining the efficiency and predictability that the Act was intended to ensure.[3]

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[2] William J. Kilberg & Paul D. Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313, 1313-14 (1984); *see* H.R. Rep. No. 93-533, at 12 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 ("The uniformity of decision which the act is designed to foster will help administrators, fiduciaries and participants to predict the legality of the proposed actions without the necessity of reference to varying state laws.").

As this Court has recognized:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants . . . [and] making disbursements . . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. [If that were the case a] plan would be required to . . . process claims in a certain way in some States but not in others . . . .

Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1, 9 (1987).

[3] Sponsors of ERISA benefit plans may fund benefits directly, or provide them by purchasing insurance. Self-funded plans are regulated entirely by federal law, *see, e.g.*, 29 U.S.C. § 1135 (giving Secretary of Labor general authority to prescribe regulations under ERISA), while insurance purchased by a plan remains subject to state regulation in important respects, *see generally UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358,

Under the federal oversight provided by ERISA, the voluntary approach to employee health coverage has been a remarkable success. Employer and union sponsors, in conjunction with employees themselves, have committed huge resources to health benefit plans. Employment-based health plans are the most common type of health coverage in the United States, and ERISA-covered group health plans cover more than 130 million Americans.[4] Indeed, such plans are the cornerstone of the country's health care financing system.

II. Cost-Effectiveness Measures Are Essential To Promote Both Quality And Cost-Efficiency In A Voluntary Employment-Based Health Benefits System

The success of the voluntary employment-based health benefits system is due not only to the relatively uniform regulatory regime established by ERISA, but also to the way that plan administrators and health insurers have been able to modify and adapt the traditional fee-for-service model of health insurance to address the special challenges posed by modern American health care economics. As a legal matter, the adaptations of "managed care," such as the step-therapy drug formulary and the hospital utilization review requirement at issue in these cases, do not differ fundamentally from the sort of "medical necessity" or "reasonable and necessary costs" limitations that have always been a feature of the coverage provided by traditional indemnity insurance. They have, however, evolved dynamically in ways that allow intelligent management of scarce plan coverage dollars, while preserving, or even enhancing, the availability and application of financial resources to pay for high-quality, truly effective patient care.

367 n. 2 (1999). In either event, the *remedies* available for allegedly improper denials of coverage by a plan administrator in individual cases are defined carefully, and exclusively, by federal law. ERISA § 502(a)(1)(B) authorizes participants and beneficiaries to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). ERISA's civil enforcement remedies constitute the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

[4] *See* Employee Benefit Research Institute, *Special Report and Issue Brief, EBRI Research Highlights: Health Benefits* 5 (May 2003).

A. Health Care Economics Pose Acute Challenges To Providing Broad, Affordable Coverage

Health care is a good for which demand is both acute and, in practical terms, inexhaustible. Moreover, notions of what is encompassed within standard "health care" coverage (as opposed to, for example, cosmetic or otherwise elective procedures) are prone to rapid expansion in a modern and relatively wealthy consumer economy. Given these robust and expanding demands, the American healthcare industry is continually generating new treatments, techniques, devices, and drugs that offer (or seem to offer) consumers of health care tremendous potential benefits—at, quite often, tremendous potential cost.

The trouble with this market dynamic lies in the way that individual health care "consumption" decisions typically get made. At a moment of need an insured patient, while the ultimate "consumer" of the care, typically lacks both the expertise to make informed decisions for himself, and any material sensitivity to price. The treating physician is guided by professional judgment and her pattern of practice, but may, as a practical matter, lack complete or fully up-to-date information about the risks and benefits (or relative costs) of all available options.[5] The physician is also likely subject to

[5] A comprehensive national study of health care quality by researchers from the RAND Foundation found a substantial gap, for a wide range of illnesses, between what practicing physicians recommend to their patients and what medical scientists would describe as appropriate treatment. Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered*

her own set of time constraints, patient-relations concerns, and financial incentives.[6] Meanwhile, a health insurer or benefit plan administrator may have the ability to centralize and take account of large amounts of relevant information on cost as well as efficacy of a particular treatment or procedure. Under the traditional fee-for-service insurance model, however, an insurer or administrator lacks effective mechanisms for factoring that information into the decision whether the plan will pay for particular proposed treatments—at least, before the costs have already been incurred.

B. Cost-Effectiveness Measures Permit Plan Sponsors To Offer The Broadest Access To High-Quality Health Benefits At The Lowest Cost

These conditions make it difficult for conventional market forces to generate health care consumption choices that make economic sense from the point of view of an employee benefit plan (and its group of beneficiaries) as a whole. Of course, a plan administrator making individual coverage decisions, or an insurer that has contracted to provide specified benefits at an agreed price, is not interested in precluding an individual beneficiary from pursuing any particular course of treatment, whatever its cost or likely effectiveness, with the beneficiary's own resources. Such an administrator or insurer is, however, centrally concerned with determining

to Adults in the United States, 348 New Eng. J. Med. 2635 (2003). Practioners failed to provide appropriate care about 46% of the time, while about 11% of the time they provided care that was not indicated or was even potentially harmful. *Id.* at 1641. The lead author concluded that "[w]e need to fundamentally re-engineer the way that health care is delivered" by relying on information technology systems, rather than individual practitioners, as the key to higher quality care. Editorial, *The Deeper Problem*, Wash. Post, June 29, 2003, at B6 (quoting Dr. McGlynn).

[6] *See Pegram* v. *Herdrich*, 530 U.S. 211, 218 (2000) ("In a fee-for-service system, a physician's financial incentive is to provide more care, not less, so long as payment is forthcoming.").

what specific costs the *plan* has or has not promised to bear. That question goes to the heart of the administrator's or insurer's obligation to manage the plan's funds prudently, on behalf of *all* the beneficiaries who are entitled, and will need, to draw on its limited resources.[7]

These concerns are critical to the ERISA model of voluntary employment-based coverage. The resources available to a plan are determined by what the sponsor and covered employees are willing to contribute. For that level of resources, the highly competitive market for group insurance or plan administration services will offer a variety of plans, adapted to the different situations or preferences of a given sponsor and employee group. The common theme of both demand and offerings, however, will be to achieve the most effective, highest quality coverage possible for the entire group, at the lowest possible cost.

In pursuing that goal, insurers and health plans—along with, and sometimes led by, public-sector care-delivery systems, such as Medicare and the Veterans Administration health system—have developed the array of cost- and quality-management techniques that are generally grouped under the heading "managed care." Like a traditional indemnity insurer, a managed-care organization (MCO) typically determines whether it will pay for particular services, prescription drugs, or other care based on whether the care received or desired was or is medically necessary and appropriately priced under given circumstances. The MCO, however, will typically use active techniques to promote the efficient use of plan funds. These may include, for example, the

[7] A plan sponsor is free to design its plan to provide any type and level of benefits it chooses. That choice does not implicate any fiduciary duty. *See, e.g.*, *Pegram*, 530 U.S. at 226-27. Once the terms of the plan have been set, determinations concerning whether an individual situation is or is not covered by those terms may have a medical aspect, but in the end they are acts of plan administration that reflect, and affect, the economics of the entire plan. They involve what care a plan has promised to pay for, not what care a doctor may recommend, or the patient may choose to receive.

sort of utilization-review procedures involved in these cases. In *Davila*, Aetna employed a standardized, evidence-based "step therapy" guideline in determining that it would not pay for an expensive new prescription drug in the absence of some documented reason not to use a clinically similar and less expensive medication. Likewise, in *Calad*, Cigna refused to promise payment for a hospital stay that exceeded the standard period its guidelines recognized as reasonable for a particular procedure, in the absence of specifc evidence that Calad's circumstances justified a longer stay. These sorts of determinations concerning what a given plan will and will not pay for, absent evidence about a particular beneficiary's specific circumstances, are core features of contemporary health-benefit management.[8]

For present purposes, there are at least three important points to be made about such benefit-management techniques. *First*, these and similar evidence-based coverage guidelines can promote, as well as constrain, use of benefits. Plans almost uniformly have, for example, established programs to promote the use of treatments that have been proven effective (such as prescribing beta blockers for heart-attack patients); to encourage preventive care, such as immunizations and diagnostic screening tests for cancer; and to promote proactive treatment-management for patients with chronic conditions such as asthma, diabetes, and heart disease.[9] The point is that insurers and plan administrators,

[8] Voluntary plans have almost universally adopted managed care techniques. In 1988, 16% of covered workers were enrolled in HMOs, whereas 73% were still enrolled in traditional indemnity insurance plans. Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey* 71 Ex. 5.1 (2003) ("Kaiser Foundation 2003 Survey"), *available at* http://www.kff.org/insurance/employer.cfm. By 1996, 27% of employees were enrolled in traditional indemnity plans, while 73% were enrolled in some form of MCO plan. This year, 95% of covered employees are enrolled in some type of MCO plan. *Id.*

[9] *See* AAHP, *Highlights of 2002 AAHP Annual Survey of Health Plans* (2003).

who compete for the business of plan sponsors and their employees, have no incentive to design systems that deny coverage for no good reason—particularly when, as is typically alleged by plaintiffs, the denial of some relatively inexpensive item or service would likely lead to a bad medical outcome that would then require additional, much more expensive, care. Rather, the interests of plan sponsors, beneficiaries, and plan administrators are all well served when evidence-based techniques are brought to bear to help ensure that the plan's resources are being used to pay as much as is necessary for care that is likely to work—but nothing extra for care that is not likely to improve either safety or outcomes.

Second, an initial decision to pre-approve payment for a particular procedure or drug is subject to rapid appeal and review within the plan structure, and then often by independent outside reviewers.[10] This sort of review is neither uncommon nor unrealistic: some 250,000 initial coverage denials are appealed annually, and many of the appeals are successful.[11] So far as appears, however, the respondents in these cases made no effort to pursue such an appeal.

Third, in important respects, the sort of coverage decisions that are made under plan pre-approval provisions are not different in kind from the "medical necessity" determinations that have always been required for coverage under any health insurance plan. The principal difference between the two is not the nature of the decision, but its structure and timing. Under a managed-care arrangement, it is clear what sorts of care require special authorization for coverage, and exactly what supporting evidence will be required. A beneficiary whose request for coverage is denied is, of course, free to seek the care at issue in any

[10] *See infra*, pp. 23-24.

[11] *See* C. Roan Gresenz et al., *Patients in Conflict With Managed Care: A Profile of Appeals in Two HMOs*, Health Affairs, July/Aug. 2002, at 189, 191.

least equal, and possibly better, survival outcomes.[18] And patients enrolled in HMOs were more likely to receive aggressive therapy for prostate cancer.[19]

- The likelihood of low-birth-rate deliveries in the California Medicaid program was lower in managed care arrangements than in the FFS payment group.[20]
- Managed care enrollees in the Wisconsin Medicaid program were more likely to receive superior prenatal care than patients enrolled in FFS plans.[21] California and Florida Medicaid maternal delivery outcomes were the same.[22]
- As a general measure of quality, 93% of patients enrolled in MCOs received recommended beta-blocker care after heart attacks, compared to 45% in the general population. Similarly, 81% of diabetes patients had their blood sugar measured regularly, compared to 24%; and 85% of pregnant women received recommended prenatal care, as opposed to 73%.[23]

The quality of care provided in a managed care setting compares equally well in the two contexts in which cost

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[18] Arnold L. Potosky et al., *Breast Cancer Survival and Treatment in Health Maintenance Organization and Fee-for-Service Settings*, 89 J. Nat'l Cancer Inst. 1683 (1999).

[19] Arnold L. Potosky et al., *Prostate Cancer Treatment and Ten-Year Survival Among Group/Staff HMO and Fee-for-Service Medicare Patients*, 34 Health Servs. Res. 525 (1999).

[20] Denise M. Oleske et al., *A Comparison of Capitated and Fee-for-Service Medicaid Reimbursement Methods on Pregnancy Outcomes*, 33 Health Servs. Res. 55 (1998).

[21] Arik Levinson & Frank Ullman, *Medicaid Managed Care and Infant Health*, 17 J. Health Econ. 351 (1998).

[22] Denise M. Oleske et al., *Effect of Medicaid Managed Care on Pregnancy Complications*, 95 Obstetrics & Gynecology 6 (2000).

[23] *Compare* National Comm. for Quality Assurance, *The State of Health Care Quality: 2002* 10 (2002) (using the "HEDIS"—Health Plan Employer Data and Information Set—measures for health plans) *with* McGlynn, *supra*, at 2642, 2643 tab. 5.

pressures are greatest, and out of which the present cases arise: prescription drug management and hospital utilization. As to drugs, a new study conducted by medical schools across the country considered patients with diabetes, congestive heart failure, and asthma, and concluded that (1) "managed care patients were more likely to use chronic disease medications than indemnity patients"; (2) "chronic disease patients in these managed care plans are more likely to receive both inexpensive and expensive medications"; (3) MCO health plans had a "markedly increased probability of using newer [drug] therapies" than indemnity plans; and (4) the differences among the two insurance groups could be explained by the fact that patients in indemnity plans "face higher out-of-pocket costs and managed care plans promote more aggressive medication use."[24] Noting that these findings may be "contrary to public perception," the authors point out that study results confirm previous research showing increased drug prescription patterns in health plans using disease-management techniques, which are not offered through traditional indemnity coverage.[25]

Similarly, as to hospitalization management, two new studies published in the New England Journal of Medicine find no adverse health impact resulting from reductions in hospital usage. By adopting a managed-care model, the Veterans Administration reduced acute-care hospital bed use by 55%. That marked decline in hospital use "did not curtail access to needed services and was not associated with serious consequences for chronically ill" beneficiaries.[26] Moreover, it did not result in a rise in non-hospital care. An earlier study, conducted by the Harvard Medical School, determined that early hospital discharge programs for mothers

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[24] Randall S. Stafford, *Chronic Disease Medication Use in Managed Care and Indemnity Insurance Plans*, 38 Health Servs. Res. 595, 595 (2003).

[25] *Id.* at 606.

[26] Carol M. Ashton et al., *Hospital Use and Survival among Veterans Affairs Beneficiaries*, 349 New Eng. J. Med. 1637, 1637 (2003).

and newborns had no effect on the health outcomes of the newborns. Shorter stays were, moreover, correlated with newborn examinations on the third or fourth day after discharge, a procedure that results in better health outcomes, and is therefore recommended by treatment guidelines.[27]

This evidence that managed-care techniques preserve or even enhance quality, while significantly restraining costs, soundly refutes any suggestion that ERISA has failed plan beneficiaries by precluding them from challenging plan administrators' *coverage* decisions under state law. It also helps explain why federal law has long actively encouraged the development and use of managed-care techniques;[28] and why public-sector health-care systems, ranging from the Veterans Administration[29] to the Federal Employees Health Benefits Program[30] and the Department of Defense's TRICARE program[31] (the latter two of which are run by private

[27] Jeanne M. Madden et al., *Effects Of A Law Against Early Postpartum Discharge On Newborn Follow-Up, Adverse Events, And HMO Expenditures*, 347 New Eng. J. Med. 2031 (2002).

[28] *See* Federal Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e-9 (requiring employers with at least 25 employees to offer a federally qualified HMO as an option to their employees); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4204(a) (1990) (repealing prohibition on physician-incentive plans in Medicare and Medicaid HMOs); Social Security Act, 42 U.S.C. § 1395mm(i)(8) (Medicare managed care); *id.* § 1396b(m) (Medicaid managed care); *id.* § 1395w-21 (Medicare+Choice).

[29] The Veterans Health Administration runs the largest health care system in the United States. *See* Ashton et al., *supra*, at 1638; VHA General Information, *at* http://www1.va.gov/Health_Benefits/page.cfm?pg=1.

[30] The Federal Employees Health Benefits Program covers 8.3 million federal employees and retirees and their families. *See* Derek Hunter, *Health Care Choice and Patient Satisfaction* (2003), *available at* http://www.heritage.org/Research/HealthCare/wm259.cfm.

[31] TRICARE, the Department of Defense's health care program for non-active-duty military beneficiaries—retired personnel and family members of personnel—covers some 8.7 million people with a budget of $22 billion; the program processes 1.8 million claims weekly. *See* Dep't of Defense, TRICARE *Stakeholders' Report* (2003), *available at* http://www.tricare.osd.mil/stakeholders/downloads/stakeholders_2003.pdf.

administrators under contract with the government), have embraced such techniques in their own operations. Benefit-management programs are not about increasing profits, or reducing care. They are about the prudent management of scarce *joint* resources, to ensure the ability to provide the *right* care to each member with a covered need.

III. Allowing State Tort Suits Challenging Plan Coverage Decisions Would Unnecessarily Increase Costs And Reduce Coverage

Although it has succeeded in providing high-quality coverage for millions of Americans, the employment-based coverage system is under severe strain. Despite the advances in cost-containment made possible by managed-care techniques, national spending on health care surpassed 14% of GDP by 2001.[32] The next year, spending per privately-insured person rose 9.6% —well over three times the rate of increase in the Nation's gross domestic product.[33]

The greatest increases in health costs arise from precisely the sources highlighted by these cases: prescription drugs and hospitalization. The cost of prescription drugs tripled in the decade after 1990, reaching $140 billion in 2001.[34] It rose almost 16% in that final year alone and over 13% last year.[35] These figures reflect an increase in usage (the number of prescriptions increased 74% from 1992 to 2002, while the U.S. population grew only 12%); increases in retail prescription prices; and a shift toward newer, higher-

[32] *See* Katharine Levit et al., *Trends in U.S. Health Care Spending, 2001*, Health Affairs, Jan./Feb. 2003, at 154, 154, 156 Ex. 2.

[33] Bradley C. Strunk & Paul B. Ginsburg, *Tracking Health Care Costs: Trends Stabilize but Remain High in 2002*, Health Affairs, June 11, 2003, at 266, 268 & Ex.1.

[34] *See* Levit et al., *supra*, at 158 Ex.5.

[35] *Id.* at 156 Ex.2; Strunk & Ginsburg, *supra*, at 268 Ex. 1.

priced name-brand drugs.[36] In light of changing age demographics and usage trends, "U.S. spending for prescription drugs is expected to continue to rise rapidly, reaching $445.9 billion (17% of personal health care spending) by 2012."[37] Overuse of antibiotics alone results in as much as $5 billion in unnecessary expenditures each year.[38]

Growth in hospitalization costs moderated in the 1990s—due in large part to strict utilization review.[39] By 2000, however, hospitalization again surpassed medication as the key cost driver,[40] and hospital costs "continue[] to drive overall health care spending trends."[41] Moreover, as with drug costs, overuse of inpatient care for medical treatments that can be performed safely in an outpatient setting unnecessarily raises both the financial and the human costs of care. According to one study, for example, preventable hospital-acquired infections claim at least 20,000, and perhaps more than 60,000, lives each year, and result in up to $18 billion in unnecessary expenditures.[42]

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[36] The Kaiser Family Foundation, *Prescription Drug Trends* 2 (May 2003) (citing www.imshealth.com), *available at* http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14267.

[37] *Id.* (citing *Health Spending Projections for 2002-2012*, Health Affairs (Feb. 7, 2003)).

[38] Midwest Business Group on Health, *Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership* iii (2003) ("MBGH Report").

[39] Bradley C. Strunk et al., *Tracking Health Care Costs: Hospital Care Surpasses Drugs as the Key Cost Driver*, Health Affairs, Sept. 26, 2001, at 39, 44-45.

[40] Strunk et al., *supra*, at 39.

[41] Strunk & Ginsburg, *supra*, at 266.

[42] *See* MBGH Report at iii. At the other extreme, underdiagnosis and inadequate treatment of diabetes results in direct and indirect costs of $132 billion annually, as well as tens of thousands of cases of premature death, amputations, kidney disease, and blindness. Underdiagnosis and the failure to use pharmacy and outpatient services to treat depression results in costs of $80 billion per year, while poor management of asthma costs $18 billion. Underuse of influenza and pneumococcal vaccinations

Whichever driver leads at any given moment, radically increasing costs in these two sectors pose a serious challenge to the continued vitality of employment-based health coverage.[43] Between spring 2002 and spring 2003, monthly premiums for employer-sponsored health insurance rose 13.9%—over six times the rate of inflation, and the third consecutive year of double digit premium increases.[44] At the same time, employees are paying an increasing percentage of plan costs, as well as larger deductibles and co-payments.[45] In turn,

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results in the death of between 10,000 and 20,000 individuals each year, while inadequate care after a heart attack results in 18,000 unnecessary deaths. In all, this survey concludes that $420 billion is spent each year as a direct result of care diverging from objective quality standards (not including indirect costs, such as reduced productivity from absenteeism, which the study estimates costs an additional $105 to $210 billion). Private purchasers absorb about one-third of these costs, which is estimated to cost the typical employer between $1,900 and $2,250 per covered employee per year. As discussed above, one of the salient promises of managed-care techniques is the potential to reduce the costs of *both* over- *and under*-utilization of care.

[43] *See* Kaiser Foundation 2003 Survey at 2 ("When employers were asked which factors contributed 'a lot' to increases in health insurance premiums, firms were most likely to point to higher spending for prescription drugs (61%) and hospital services (55%).").

[44] *See id.* at 1.

[45] *See* Mercer Human Resource Consulting, *Surprise Slow-Down In US Health Benefit Cost Increase: Employers Shift Costs To Employees, Take Steps To Improve Workforce Health* (Dec. 8, 2003) (summarizing Mercer's *National Survey of Employer-Sponsored Health Plans 2003*), *available at* http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1121535;jsessionid=NEIHSHTI0U0EGAAJAADQOCAKMZSI4I2C; Milt Freudeinheim, *Employees Paying Ever-Bigger Share for Health Care*, N.Y. Times, Sept. 10, 2003, at Al (reporting on Kaiser Foundation 2003 Study showing that almost 2/3 of large employers that sponsored health plans raised the amounts that employees are contributing to the cost of their health plans this year, and 79% say they will do so again in 2004); The Business Council of New York State, Inc., *Compensation Data New York 2003* (2003) (survey of New York employers reflects that, in a 12-month period ending in April 2003, more than 1/3 of employers increased the employee portion of health insurance premiums, and nearly 1/3 increased deductible levels). The Kaiser Foundation reports that recently there has been "a greater level of interest"

rising health insurance premiums have been "clearly linked" to rising rates of the uninsured.[46]

Particularly in light of these existing pressures on voluntary employer health plans, the Fifth Circuit was wrong to adopt an interpretation of federal law that would permit state tort suits based on plan coverage decisions. To begin with, of course, that interpretation is untenable in light of ERISA itself and this Court's cases, as the petitioners' briefs amply demonstrate. Even if the statute and precedents were less clear, however, allowing such suits would be deeply misguided.

1. *First*, there is no need to permit state tort suits in order to protect ERISA beneficiaries. Despite what one might infer from the stories included by plaintiffs' lawyers in their complaints (and perforce accepted by judges *as though* true for purposes of ruling on motions to dismiss), there is no reason to think that there is a widespread problem of plan participants wrongly denied coverage for necessary care, and then subjected to bad medical outcomes that would have been prevented had the desired drug or service been provided. To the contrary, as discussed above, the incentives of sponsors, employees, and plan administrators in this regard are aligned, not antagonistic. MCOs deny only a small percentage of coverage claims, and only a few of those denials are based on a failure to meet pre-authorization criteria.[47]

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among very large employers in insurance featuring very high deductibles (over $1000). *See* Kaiser Foundation 2003 Study at 2-3. Because such employers "historically have been innovators in the market, [this] may portend future growth of this option." *Id.*

[46] Strunk & Ginsburg, *supra*, at 266.

[47] Of the less than 2% of plan enrollees who are initially denied coverage, *see* Carole Roan Gresenz et al., *A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries* (1999), *available at* http://www.rand.org/publications/IP/IP184/, only *6%* of denials resulted from failure to meet pre-authorization criteria, compared to denials because of: filing of duplicate claims (18%); prior payment of a capitated rate (10%); failure to adhere to plan procedures (including failure to request pre-authorization) (18%);

Moreover, as discussed above, health outcomes under managed-care arrangements typically equal or surpass those under traditional fee-for-service plans.[48] Plan coverage guidelines are designed to provide, not withhold, payment for care—*if* the objective medical evidence suggests that that care is likely to produce a better outcome than some other alternative.

Moreover, all plans have mechanisms available for the fast internal review, and often for independent outside review, of coverage denials. ERISA itself requires procedural protections such as effective notice of coverage denials and a reasonable opportunity for review of such decisions,[49] and the Secretary of Labor has issued comprehensive regulations governing the appeal process that include requiring, when appropriate, review in consultation with a medical professional,[50] and initial and final decisions that provide specific reasons for denial, and references to pertinent plan provi-

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submission of incomplete or inaccurate information (14%); or the fact that the patient is not a plan member (7%). *See* AAHP, *Portrait of a Changing HMO Industry* 3 & fig. 2 (2001).

[48] *See supra*, pp. 14-19.

[49] *See* 29 U.S.C. § 1133(1) ("In accordance with regulations of the Secretary, every employee benefit plan shall . . . provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant . . . ."); *id.* § 1133(2) (plans must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim").

[50] *See* 29 C.F.R. § 2560.503-1(h)(1) (benefit plan must establish and maintain a procedure "under which there will be a full and fair review of the claim"); *id.*§ 2560.503-1(h)(2)(iv) (plan must "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim"); *id.* § 2560.503-1(h)(3)(iii), (4) ("[I]n deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment," the administrator "shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.").

sions.[51] Every state also requires MCOs to establish consumer grievance and appeals processes for their insured plans,[52] and 42 states and the District of Columbia accord beneficiaries the right to appeal denials of insurance coverage to an independent medical review entity.[53]

The resulting appeals structure offers plan beneficiaries effective review. Indeed, initial coverage denials are reversed about half the time, even when appeals arise *after* a beneficiary has undergone treatment, without first securing plan authorization.[54]

Finally, there is the familiar remedy that Congress chose to provide in ERISA: A suit "to recover benefits due to [a beneficiary] under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Importantly, that remedy is as practical and effective today as it was 30 years ago to a plan beneficiary who had a dispute with a plan or insurer about the coverage of a given treatment, drug, or service under the terms of a wholly traditional, indemnity-style health insurance plan.

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[51] *See* 29 C.F.R. § 2560.503-1(g) (initial decision); *id.* § 2560.503-1(j)(1), (2) (final decision).

[52] *See* Lillian MacEachern, Health Policy Tracking Service, *Issue Brief: Consumer Grievance Procedures: Internal & Independent Appeals (Year-End Report - 2002)* (2002).

[53] *See* National Conference of State Legislatures, *Managed Care Insurer Liability* (2003), *available at* http://www.ncsl.org/programs/health/liable.htm (updated Nov. 3, 2003); *see also Rush Prudential HMO* v. *Moran*, 536 U.S. 355 (2002) (Illinois statute requiring HMOs to provide independent review was not preempted by ERISA, where HMO was properly treated as an insurer).

[54] *See* AAHP, *Independent Medical Review of Health Plan Coverage decisions: Empowering Consumers With Solutions* 1 (2001) (concluding that 49% of cases decided by independent review are reversed); *see also* Gresenz et al., *A Flood of Litigation?*, *supra*, at 189 (enrollees won 36% of prospective appeals and 89% of retrospective appeals in one large HMO studied, and 70% of prospective and 78% of retrospective appeals in the other).

There is, accordingly, no reason to think that simply because coverage determinations are now often made earlier and in a more organized manner, the remedy that Congress originally provided for coverage disputes has somehow become inadequate or in need of supplementation.

2. *Second*, allowing state suits regarding coverage decisions would be affirmatively harmful. The prospect of such litigation would significantly complicate plan design, funding, and administration. Contract-based costs of expected care, relatively predictable over groups of beneficiaries, will be subject to unpredictable, but quite possibly significant, potential tort liabilities. That sort of uncertainty will make it difficult for sponsors and administrators to budget, including setting appropriate employee premiums, deductibles, or co-payment amounts. Moreover, differing state standards will hinder the implementation of nationwide, evidence-based coverage guidelines and care initiatives (such as disease-management plans), and the uniform administration of both benefits and review mechanisms for initial coverage decisions. At a minimum, these new complications would materially increase the cost of providing coverage through a voluntary plan, and thus undermine a core purpose of ERISA's uniform regulatory scheme. As one commentator has put the point:

> Removal of ERISA preemption and adoption of more state liability laws could lead to an environment where HMOs and managed care plans are defending a number of lawsuits against a number of different plaintiffs in a number of different states arising under a number of different types of causes of action. This is exactly the environment from which Congress was trying to protect employee benefit plans generally when it enacted ERISA in 1974.[55]

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[55] Matthew J. Binette, Comment, *Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster?*, 81 N.C. L. Rev. 653, 693-94 (2003).

The response of plan sponsors and administrators is not hard to predict. Some will restrict benefits, and/or increase required employee contributions, to counter-balance the higher costs of running their plans. Others will seek to avoid litigation over individual coverage determinations by removing any discretionary element from their coverage categories—thus contracting, not expanding, the availability of benefits in cases where the cost-effectiveness of treatment is debatable. Still others may discontinue, or decline to adopt, health care coverage entirely, rather than face the uncertainty, litigation exposure, and certainly higher costs that would accompany the new regime.[56] In any event, the decision below will significantly undermine Congress' goal of encouraging employment-based health coverage, without promising any commensurate increase in protection for those individuals who do remain covered by ERISA plans.

[56] While nearly all large employers (those with 200 or more workers) presently offer health benefits, the figure for smaller companies is only 65%. Kaiser Foundation 2003 Survey at 38.

CONCLUSION

The decisions of the court of appeals should be reversed.

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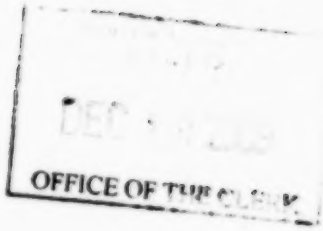

IN THE
Supreme Court of the United States

AETNA HEALTH INC. F/K/A
AETNA U.S. HEALTHCARE, INC., ET AL.,
Petitioners,

v.

JUAN DAVILA,
Respondent.

&

CIGNA HEALTHCARE OF TEXAS, INC. D/B/A
CIGNA CORPORATION,
Petitioner,

v.

RUBY R. CALAD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS AS AMICUS CURIAE SUPPORTING REVERSAL

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INTEREST OF THE AMICUS CURIAE

The Association of Federal Health Organizations ("AFHO") is a trade association of employee organizations and other entities that sponsor experience-rated fee-for-service health benefits plans governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. FEHBA is the federal statute authorizing the United States Office of Personnel Management ("OPM") to establish and regulate health benefits plans for federal employees, retirees, and their dependents. Under FEHBA, a plan is experience-rated if its premiums are based on that plan's historical cost of providing benefits to its enrollees. *Id.* § 8902(i). AFHO's members sponsor some of the largest FEHBA plans in the nation; collectively, they provide health benefits to nearly five million enrollees.[1]

These cases concern the scope of federal jurisdiction and preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* In prior cases, some federal courts have held that preemption over claims concerning FEHBA plans is co-extensive with preemption under ERISA. *See, e.g., Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002); *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 849-51 (9th Cir. 2002); *Corporate Health Insurance, Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir. 2000), *vacated on other grounds*, 536 U.S. 935 (2002). Oftentimes, these courts have treated "ERISA and FEHBA cases interchangeably." *Botsford*, 314 F.3d at 394.

In light of these courts' similar treatment of ERISA and FEHBA preemption, AFHO has an interest in ensuring that the right result is reached on ERISA preemption in the instant cases. AFHO believes the Fifth Circuit's ruling that

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[1] In accordance with Rule 37.6, AFHO certifies that counsel for a party did not author this brief in whole or in part and that no entity other than AFHO, its members, or its counsel made a monetary contribution to the preparation or submission of the brief.

there is no federal jurisdiction or ERISA preemption in these cases is erroneous, and it accordingly files this brief in support of reversal. In addition, AFHO's position is that FEHBA preemption, in reality, is significantly and appropriately broader that ERISA preemption. Thus, while a decision in favor of ERISA preemption would necessarily mean that similar state law claims against a FEHBA plan would be preempted, a decision unfavorable to ERISA preemption should not inevitably be transferred to the FEHBA setting. AFHO files this brief in an effort to help ensure that, in the event the Court were to hold that ERISA does not preempt the state law claims involved in these cases, the Court does not speak so broadly as to cause inadvertently lower courts reflexively to apply the decision's holding to FEHBA plans. Indeed, if appropriate, AFHO respectfully requests that the Court state that any decision here rejecting preemption is limited to the ERISA context and does not address the scope of preemption under FEHBA or any other federal program.

Counsel for the parties have filed letters with the Clerk of the Court consenting, in global manner, to the filing of all *amicus* briefs supporting either side in these actions.

SUMMARY OF ARGUMENT

A. To determine if ERISA completely preempts state law negligence claims disputing denials of benefits based on lack of medical necessity, the critical question is whether Congress intended ERISA's remedies to challenge such denials to be exclusive. It did. First, this Court has already held that Congress meant for the remedies contained in ERISA § 502 to be the exclusive vehicle for disputing the processing of benefits claims. Nothing suggests that Congress intended a different rule to apply to the processing of health benefits based on medical-necessity determinations. Second, ERISA's preemption section, which makes the subject matter it covers an exclusive federal domain, encompasses Respondents' state law causes of action.

Consistent with ERISA's preemption provision, a cause of action that authorizes relief on account of a plan's determination whether or not to pay for certain treatments or supplies necessarily "relates to" the plan.

Third, ERISA's central goal of ensuring uniform plan administration bolsters the exclusivity of ERISA's remedies for disputing medical-necessity determinations. If state law remedies were available, benefits would differ from state to state depending on a particular state's standards of medical reasonableness. Fourth, that medical-necessity decisions involve the exercise of fiduciary obligations supports the exclusivity of the available ERISA remedies, since the Court has never permitted state law to set the parameters for fiduciary conduct. Though *Pegram v. Herdrich*, 530 U.S. 211 (2000), found a physician's decisions concerning treatment that also affect eligibility for benefits not to involve fiduciary behavior, that decision should not be extended to plans making medical-necessity determinations. Fifth, Congress's recent consideration, but rejection, of legislation that would have allowed causes of action similar to Respondents' helps prove that ERISA as originally enacted was not intended to allow for state law remedies for grievances concerning medical-necessity decisions.

B. While the case for federal jurisdiction and preemption under ERISA is overwhelming, the arguments under FEHBA are even stronger. Consequently, in the event the Court were – despite the force of the ERISA case – to hold that ERISA does not completely preempt Respondents' state law claims, it should limit any such ruling to ERISA plans.

Because FEHBA plans are established via federal government contracts, litigation involving FEHBA plans – unlike disputes involving ERISA plans – implicates "uniquely federal interests" and triggers a relaxed standard for preemption. Additionally, among other considerations indicating a broader preemptive scope under FEHBA than

ERISA are: FEHBA's insistence that a federal agency – OPM – have sole authority to adjudicate benefits disputes; a preemption provision expressly aimed at permitting managed-care programs to thrive; a Congressional desire that there be not only uniform benefits among FEHBA plans but that there also be uniform rates; and recent legislative activity to expand, rather than diminish, FEHBA preemption.

ARGUMENT

I. ERISA COMPLETELY PREEMPTS RESPONDENTS' MEDICAL-NEGLIGENCE CLAIMS

The precise issue involved in these cases is whether ERISA completely preempts, and therefore makes removable to federal court, state law negligence claims challenging a health plan's denials of benefits that are based on lack of medical necessity. This Court very recently clarified the standard for determining whether a federal statute completely preempts state law claims. The "proper inquiry focuses on whether Congress intended the federal cause of action [contained in the federal statute] to be exclusive." *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2064 n.5 (2003). Thus, if Congress intended ERISA's remedies to be the exclusive means for disputing a plan's denial of health benefits on the grounds of lack of medical necessity, then complete preemption exists. All of the salient factors indicate that, in fact, Congress did contemplate ERISA's enforcement scheme providing the exclusive remedy in such cases.

A. The Court Has Already Held that ERISA's Remedies Are Exclusive as to Similar Claims for Benefits

ERISA's enforcement scheme is set out in ERISA § 502, 29 U.S.C. § 1132. That section establishes six different causes of action for grievances associated with the administration of ERISA plans. For present purposes, the

most notable are the cause of action in § 502(a)(1)(B) available to a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan"; and the causes of action in §§ 502(a)(2) and 502(a)(3) for breaches of fiduciary duty.

The Court has already held that these remedies are "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). Reviewing § 502, the Court said in *Pilot Life* that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 54. The Court recently reaffirmed *Pilot Life*, *see Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002), and it has never wavered from the guiding principle that there shall be no "alternate enforcement mechanisms" to § 502. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)).

The Court has not only held that ERISA's remedies are exclusive, but that they completely preempt state law "causes of action asserting improper processing of a claim for benefits." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 60 (1987). The Court in *Metropolitan Life* held that "a suit by a beneficiary to recover benefits from a covered plan . . . falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63. Finding such suits to be "necessarily federal in character by virtue of the clearly manifested intent of Congress," the Court ruled that that they "'arise[] under the . . . laws . . . of the United States,' 28 U.S.C. § 1331, and

[are] removable to federal court by the defendants." *Id.* at 67.

Unless some special rule is to exist for claims for health benefits where the chief issue is medical necessity, the holdings in *Pilot Life* and *Metropolitan Life* are dispositive of Respondents' claims. Respondents had ERISA remedies available to them, and – under *Pilot Life* and *Metropolitan Life* – those remedies are their exclusive means for challenging their health plans' denials of benefits.

For instance, with respect to Respondent Davila's claim, he could have brought an immediate injunctive action under § 502(a)(1)(B) for benefits or to "enforce his rights under the terms of his plan," if he believed that his health maintenance organization ("HMO") had, in denying him the prescription drug recommended by his physician, erroneously implemented the plan's medical-necessity requirements. The federal court could have issued a temporary restraining order or preliminary injunction compelling the HMO to pay for Vioxx, in the event Davila were correct in his allegations.

Another option would have been for Respondents to undergo the treatment that their physicians recommended and then file a claim for benefits. Put in terms of Respondent Calad's case, she could have sought to pay for the additional time in the hospital and then, invoking § 502(a)(1)(B), filed suit in federal court for reimbursement of her costs. The federal court would have full authority to order the payment of benefits, in the event the HMO misinterpreted the plan's medical-necessity requirements.

Nothing in ERISA suggests health benefits claims involving medical-necessity determinations should be excepted from the holdings of *Pilot Life* and *Metropolitan Life*. Congress ordained that ERISA should encompass both pension and welfare benefit plans, with health benefit plans being among the latter. *See* ERISA § 3(1), 29 U.S.C. § 1002(1) (definition of welfare plan). Nor did Congress anywhere single out any species of benefits denials – such as

those based on lack of medical necessity – for less favorable treatment under ERISA. Without any statutory limitation, § 502(a)(1)(B)'s remedies are available to collect benefits and to enforce and clarify rights under the terms of a plan. So long as medical-necessity requirements are part of an ERISA plan's terms, disputes involving them should fall exclusively within ERISA's enforcement scheme to resolve.

B. ERISA's Preemption Section Confirms That the Statute's Remedies to Challenge Medical-Necessity Denials Are Exclusive

ERISA's preemption provision offers further evidence that, with respect to claims for benefits involving medical-necessity issues, Congress intended the statute's remedies to be exclusive. That section states that "the provisions of [ERISA] shall supersede and preempt any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. ERISA § 514(a), 29 U.S.C. § 1144(a). As is now familiar, this Court has repeatedly emphasized the breadth of ERISA's preemption provision. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) (noting that Court has, in its precedents, termed ERISA's preemption section as "clearly expansive," having "a broad scope," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded") (internal quotation marks and citations omitted); *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001).

With the preemption provision, "Congress's intent [was] to establish the regulation of employee welfare benefit plans 'as *exclusively* a federal concern.'" *Travelers*, 514 U.S. at 656 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)) (emphasis added); *accord FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (ERISA "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by

ERISA"). Citing to ERISA's legislative history, the Court has noted that ERISA's provisions "are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *Travelers*, 514 U.S. at 657 (quoting 120 Cong. Rec. 29,933 (1974) (statement of Senator Williams)).

To be sure, this Court has, in recent years, also emphasized that it begins any ERISA preemption analysis with a "presumption against pre-emption." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). "[W]here federal law is said to bar state action in fields of traditional state regulation, [the Court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Travelers*, 514 U.S. at 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (internal citation omitted). And the Court has added that that presumption is particularly strong with respect to "general health care regulation, which historically has been a matter of local concern." *Id.* at 661.

Notwithstanding that presumption, one of the Court's most recent ERISA decisions held that ERISA's preemption clause encompasses state laws requiring that health plans allow for external review of denials of benefits that are based on medical necessity. *Rush Prudential*, 536 U.S. at 365. In *Rush Prudential*, the Court found it "beyond serious dispute that under existing precedent [the state law] 'relates to' employee benefit plans within the meaning of § 1144(a)," though the Court ultimately held that statute was saved from preemption with respect to insured employee benefit plans because of ERISA's savings clause excepting from preemption state insurance, banking, and securities regulations. *Id.*; *see generally* ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (ERISA's savings clause).

Just as in *Rush Prudential*, this case falls within the parameters of ERISA's preemption provision. If a state law authorizing challenges of medical-necessity determinations to external reviewers "relates to" an ERISA plan, then so too must a state law cause of action that authorizes such challenges in court. In both instances, the state measures become pertinent only when the plan makes a benefits determination, a core ERISA-plan function. Indeed, because so much of the day-to-day administration of health plans is focused on evaluating specified treatment options against plan terms such as medical-necessity definitions or exclusionary language for experimental or investigational treatments, state law medical-negligence claims potentially strike at the heart of what health plans do. Unlike other instances where the state laws at issue, such as state tax measures or wage laws, had only "indirect" impact on ERISA plans, *Travelers*, 514 U.S. at 662; *see Dillingham*, 519 U.S. at 334, state law negligence causes of action aimed at medical-necessity decisions constitute "direct regulation of ERISA plans." *Travelers*, 514 U.S. at 668.

Given, then, that Respondents' claims fall within the area covered by ERISA's preemption provision, an area that Congress intended to be of *exclusive* federal concern, it follows that Congress would have contemplated ERISA's remedies to be the only ones available for Respondents' grievances. With the test for complete preemption centering on whether "the federal statute[] at issue provide[s] the exclusive cause of action for the claim asserted," *Beneficial Nat'l Bank*, 123 S. Ct. at 2063, the result under ERISA's preemption clause verifies the propriety of complete preemption over Respondents' claims.

C. ERISA's Goal of Uniformity Supports Complete Preemption of Medical-Negligence Claims

Undergirding ERISA's preemption section, as well as the Court's insistence that the states shall not supply

alternative enforcement remedies, is Congress's desire for nationally uniform administration of ERISA plans.

> Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."

Travelers, 514 U.S. at 656-57 (quoting *Ingersoll-Rand*, 498 U.S. at 142); *accord Egelhoff*, 532 U.S. at 150.

The only disuniformity Congress contemplated was through ERISA's savings clause for insurance, banking, and securities regulations. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 376 n.6 (1999) ("'disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation'") (quoting *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 747 (1985)). But there is no argument in these cases that state law negligence causes of action are insurance laws, and the Fifth Circuit certainly made no such holding. Consequently, Congress's objective of uniformity applies with full force to Respondents' claims.

Holding that ERISA's remedies to challenge medical-necessity denials are exclusive, and thus competent to completely preempt Respondents' claims, furthers Congress's objective of uniformity. To import the various states' standards on what is medically reasonable in particular circumstances would lead to divergent outcomes within ERISA plans. One state's standards might result in a particular treatment being medically necessary; another state, in the very same situation, conceivably might deem a health plan's denial of benefits for lack of medical necessity to be

entirely reasonable. The consequence would be that participants in one state may obtain benefits that are properly denied in another state. Particularly because so many of a health plan's decisions are tinged with medical-necessity considerations, the resulting disuniformity would be pervasive. Deeming ERISA's remedies for medical-necessity denials to be exclusive avoids that subversion of ERISA's fundamental concern for uniformity.

D. A Health Plan's Denial of Benefits Based on Medical Necessity Involves a Fiduciary Determination

Because any denial of benefits by a health plan based on medical necessity involves fiduciary action, ERISA's remedies exclusively should govern. The Court has never held that state law may regulate the behavior of ERISA fiduciaries. And a determination to provide or deny benefits does involve fiduciary duties. A plan owes a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims." *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). In the case of medical-necessity determinations, plans typically apply definitions of medical necessity contained in plan documents, in order to determine whether to pay for or deny benefits for treatment. Moreover, in determining what is and is not medically necessary, plans "exercise[] discretionary responsibility in the administration of [the] plan," which is the hallmark of an ERISA fiduciary. ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). As conduct of a fiduciary, only ERISA's remedial scheme (and, for that matter, ERISA's substantive standards) should control.

That a plan's denial of benefits based on lack of medical necessity involves fiduciary behavior is proven by the detailed claims regulations issued by the Department of Labor ("DOL"). *See* 29 C.F.R. Pt. 2560. These regulations set out specific timeframes for making determinations concerning health benefits, whether the benefits claim is

post-treatment, pre-treatment, concurrent with treatment, or involves urgent care. The DOL regulations also set forth appeal procedures for denials of benefits, including a requirement that, if a denial involves a medical judgment, the plan must consult during the appellate process with a health care professional who is independent of anyone involved in the initial denial. *Id.* § 2560.503-1(h)(3). If medical-necessity determinations did not involve fiduciary decisions, and were instead matters for state regulation, the DOL would have no basis for exercising its authority to establish standards of conduct.

The sticking point, of course, is *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000), where the Court held that an HMO physician's determinations concerning medically appropriate care "are not fiduciary decisions under ERISA." Though the Court's decision there can be cabined to apply only to *initial physician* determinations concerning treatment, the Fifth Circuit in these cases expanded *Pegram*'s holding to encompass subsequent administrative determinations made by the HMO based on medical necessity – determinations that were contrary to the treating physician's initial recommendations. The Fifth Circuit relied on a passage in *Pegram* where the Court suggested that HMOs might never be able to live up to the fiduciary standard. Whereas a fiduciary "must 'act solely in the interest of the patient without possibility of conflict,'" the "entire purpose" of HMOs "is to balance costs against patient welfare." *Roark v. Humana, Inc.*, 307 F.3d 298, 308 (5th Cir. 2002) (quoting *Pegram*, 530 U.S. at 233).

The Fifth Circuit's extension of *Pegram* from a situation involving physicians to circumstances involving HMOs or other entities administering ERISA plans was misguided. Contrary to the Fifth Circuit's holding (and even to the suggestion in *Pegram*), the mission of HMOs and other health plans is consistent with ERISA's fiduciary obligations. The duty of a health plan fiduciary is not simply to act singly

with an eye toward a patient's wishes; rather, "[t]he common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of *all* beneficiaries." *Varity*, 516 U.S. at 514 (emphasis added). Where an HMO applies the medical-necessity definition contained in plan documents (as it must under ERISA's fiduciary responsibilities, ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D)) and, in so doing, denies a participant's preferred treatment option in favor of a less expensive one deemed to be medically appropriate, the HMO conserves resources for the benefit of all beneficiaries. That is not simply the "ration[ing]" of care for rationing's sake, but the efficient balancing of cost and treatment considerations, as the ERISA plan sponsor likely anticipated would occur when it purchased HMO coverage. *Roark*, 307 F.3d at 308; *see* ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (providing that fiduciary decisions must take into account the interests of all participants and beneficiaries).

In sum, a health plan's evaluation of a physician's recommended treatment regimen, for compliance with medical-necessity requirements, implicates ERISA fiduciary duties. Because the plan determinations involved in these cases therefore involved fiduciary action, ERISA's enforcement scheme is the exclusive remedy for disputing the determinations.

E. Congress's Consideration of Legislation to Permit Medical-Negligence Claims Against ERISA Plans Proves That ERISA Currently Does Not Countenance Such Claims under States Law

Congress's recent consideration of legislation to limit ERISA preemption and allow for state law medical-negligence claims against health plans further illustrates that – in its original enactment of ERISA – Congress

intended the federal remedies to be exclusive. In this regard, Congress has, in recent times, repeatedly considered so-called "Patients' Bill of Rights" legislation. *E.g.*, H.R. 2563, 107th Cong. (2001); S. 1052, 107th Cong. (2001); H.R. 2990, 106th Cong. (1999). These bills, to varying degrees, would have lifted the umbrella of ERISA preemption to allow for state law medical-negligence claims against ERISA plans whose benefits determinations involve medical judgment and allegedly were erroneous.

Congress would have no need to consider such legislation if, in fact, ERISA as currently in force permitted state law challenges to medical-necessity decisions, in addition to the available federal avenues for relief. Merely because Congress has not been able to agree on any changes to the current preemption structure does not mean the Court should, through judicial decision, adopt what Congress so far has not. As it stands now, the remedies for disputing a denial of benefits based on lack of medical necessity are exclusively contained in § 502. Because the federal remedies are exclusive, they completely preempt Respondents' claims, and federal jurisdiction should have been exercised in these cases.

II. FEHBA PROVIDES EVEN MORE SUBSTANTIAL GROUNDS THAN ERISA FOR COMPLETE PREEMPTION OF MEDICAL-NEGLIGENCE CLAIMS

Various considerations, then, lead to the conclusion that § 502 provides the exclusive remedy for ERISA disputes involving denials of health benefits based on lack of medical necessity, with exclusivity, in turn, being the prerequisite for complete preemption. These same considerations – ranging from judicial prohibitions against alternative enforcement schemes, to the text and policies of the pertinent preemption provision, to legislative action – even more clearly favor the exclusivity of the available remedies under FEHBA. Thus, a

finding in these cases in favor of complete preemption under ERISA necessarily should lead to a similar finding for FEHBA plans. The converse, however, does not follow. Because federal jurisdiction and preemption are more readily secured under FEHBA, a ruling that ERISA does not completely preempt Respondents' claims should not answer the question whether FEHBA completely preempts a dispute involving a denial of benefits based on medical-necessity criteria.

A. One overarching factor making FEHBA a stronger candidate for complete preemption than even ERISA is that the threshold for preemption is markedly lower in FEHBA cases than in ERISA matters. FEHBA covers an area of "uniquely federal interest"; and in areas of uniquely federal interest, "[t]he conflict with federal policy need not be as sharp as that which must exist for ordinary pre-emption when Congress legislates 'in a field which the States have traditionally occupied.'" *Boyle v. United Techs. Corp.*, 487 U.S. 500, 507 (1988) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). "Or to put the point differently, the fact that the area in question *is* one of unique federal concern changes what would otherwise be a conflict that cannot produce pre-emption into one that can." *Id.* at 507-08; *see also Buckman v. Plaintiffs' Legal Committee*, 531 U.S. 341, 347-48 (2001).

FEHBA authorizes OPM to contract with private carriers to provide health benefits for federal employees, retirees, and their dependents. 5 U.S.C. § 8902(a). Accordingly, FEHBA plans are established through federal government contracts. "No insurance contract exists . . . between the [enrollees] and [their FEHBA plan]"; "[i]nstead, the [individuals] are enrollees in a federal health insurance plan underwritten by [the carrier] and are subject to regulations promulgated by OPM." *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1030 (E.D. Tenn. 1999); *accord Caudill v. Blue Cross & Blue Shield of N.C.*,

Inc., 999 F.2d 74, 76 (4th Cir. 1993). The government pays the majority of the premium price for enrollees, with the enrollee paying the remainder. 5 U.S.C. § 8906.

FEHBA leaves to OPM the task of selecting the benefits that a particular FEHBA plan shall provide. The statute directs OPM to procure such health benefits as the agency "considers necessary or desirable." 5 U.S.C. § 8902(d). In conjunction with this authority, OPM issues to all enrollees in each FEHBA plan a "Statement of Benefits." *See id.* The Statement of Benefits sets forth the "benefits, including maximums, limitations, and exclusions"; the "procedure for obtaining benefits"; and the "principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). It is part of the government contract governing the FEHBA plan. *See id.* § 8902(d).

Given the government's subsidization, a federal agency's guiding role, and the FEHBA program's effect on the government's own employees, the courts have already held that litigation over FEHBA benefits implicates uniquely federal interests, thereby triggering *Boyle*'s lower preemption threshold. "The interest in [a dispute over FEHBA benefits] is uniquely federal because it involves health benefits for federal employees across the country." *Caudill*, 999 F.2d at 78; *accord Rievley*, 69 F. Supp. 2d at 1037; *Kight v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d 334, 341-42 (E.D. Va. 1999). Thus, "the mere possibility of conflict and attendant damage to federal interests is sufficient" for preemption. *Caudill*, 999 F.2d at 79. Moreover, in *Boyle*, the Court held broadly that "the civil liabilities arising out of the performance of federal procurement contracts" is a matter of "uniquely federal interest." *Boyle*, 487 U.S. at 505 (internal quotation marks omitted). Any judgment against a carrier administering a FEHBA plan likewise constitutes a civil liability arising from the performance of a government contract and therefore should also involve uniquely federal interests.

Because FEHBA cases implicate uniquely federal interests, the Court begins its analysis with an eye toward the preemption of state law remedies. That contrasts with the strongly worded presumption against preemption that the Court has, in recent ERISA cases, invoked.

B. Reminiscent of ERISA, FEHBA does not tolerate "alternative mechanism[s] for enforcing FEHBA-created rights," in addition to FEHBA's remedies. *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 397-98 (9th Cir. 2002). FEHBA contains a "single" remedy for an enrollee to challenge denials of benefits, whether based on lack of medical necessity or for any other reason. *Kight*, 34 F. Supp. 2d at 342; *accord Botsford*, 314 F.3d at 398 ("the federal remedies provided to aggrieved federal employees under the regulatory scheme are the only intended remedies under FEHBA"); *Bryan v. OPM*, 165 F.3d 1315, 1318 (10th Cir. 1999) (under FEHBA, "only one remedy is available"). That remedy, outlined in detail in OPM's regulations, is an administrative appeal at OPM to challenge a carrier's denial of benefits, followed by judicial review in federal court of OPM's final decision either affirming or denying the carrier's initial decision. *See* 5 C.F.R. §§ 890.105, 890.107; 48 C.F.R. § 1652.204-72.

Congress expressly directed that OPM create such a remedy. It instructed that "[e]ach contract . . . shall require the carrier to agree *to pay for or provide a health service or supply* in an individual case if the Office finds that the employee, annuitant, family member, or spouse is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j) (emphasis added). In light of its directive that OPM shall determine the availability of benefits in individual cases, Congress enacted only a limited jurisdictional provision in FEHBA – for suits against the United States. *See* 5 U.S.C. § 8912 ("The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the

United States founded on this chapter."). Furthermore, considering the fact that OPM – not the carriers – has final responsibility for determining the availability of benefits or services, the agency has prohibited all suits against carriers. *See* 5 C.F.R. § 890.107(c) (noting that challenge to "denial of health benefits must be brought against OPM and not against the carrier or the carrier's subcontractors").

While both ERISA and FEHBA create exclusive federal remedies for disputes over benefits (the benchmark for complete preemption), what makes FEHBA's enforcement scheme even more capable of preemption is that a federal agency – OPM – has the central role. It not only is responsible for selecting the available benefits, but for adjudicating all disputed benefits claims. In delegating such authority to OPM, Congress intended for "consistency" in the manner in which all FEHBA plans are administered. *Caudill*, 999 F.2d at 79. Allowing alternative remedies therefore creates an acute problem under FEHBA: it would "undercut" the consistency that Congress expected and leave to other parties (namely state court judges and juries) the task of interpreting FEHBA plans that Congress expressly expected only OPM to undertake. *Id.*

C. FEHBA contains a preemption provision that is even more pointedly aimed at ousting state law remedies relating to benefits than is ERISA's. The provision, in its current form, states:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State of local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (2000).

The current provision, which came into being in 1998 and amended a preemption provision narrower in scope, *see* Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, was specifically designed to invite complete preemption in disputes over benefits. The amendment's purpose was to "confirm[] the intent of Congress that . . . FEHBA program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) *completely displace* State or local law relating to health insurance or plans" and to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." H.R. Rep. No. 105-374, at 9, 16 (1997) (emphasis added).

FEHBA's preemption provision is unique in comparison to ERISA's because it turns on the provisions of the federal government contracts that OPM enters with carriers. Whereas the Court has said that private parties to an ERISA plan may not avoid the application of otherwise applicable state law by adding contrary terms to the plan, *see UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375-76 (1999), FEHBA's preemption provision gives the parties to FEHBA contracts (albeit, one of them being the government itself) the authority to draft contract terms "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" that shall unqualifiedly supersede state law relating to health insurance or plans. That is significant for these cases because definitions of medical necessity contained in FEHBA Statements of Benefits automatically would preempt state law standards concerning medical reasonableness, the area that the Court has been careful in its ERISA cases to say will not lightly be disregarded.

Additionally, FEHBA's preemption provision directly addresses the managed-care issues raised in these cases. When it amended FEHBA's preemption section in 1998, one change Congress made was to add that FEHBA contract

terms relating to the "provision" of benefits and coverage shall preempt state law, whereas previously the amendment had focused simply on contract provision relating to the nature or extent of coverage or benefits. *Compare* 5 U.S.C. § 8902(m)(1) (1994) *with* 5 U.S.C. § 8902(m)(1) (2000). Congress added that language in order to make clear "that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, *including managed care programs*." H.R. Rep. No. 105-374, at 16 (emphasis added). With the amendment, Congress sought to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." *Id.* at 9.

Hence, whereas ERISA's preemption provision speaks broadly about preempting all state laws relating to plans, and that text has sometimes proven "unhelpful" and "frustrating" when seeking to determine the exact contours of ERISA preemption, *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995), FEHBA's preemption provision unmistakably addresses the very managed care issues that medical-necessity determinations entail. Consistent with FEHBA's preemption section, state law causes of action may not interfere with the FEHBA plan's determination that the provision of any service or supply is, or is not, medically necessary.

D. Just as Congress sought interstate uniformity in the manner in which an ERISA plan is administered, a chief Congressional goal underlying FEHBA is "uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am., Inc.*, 819 F.2d 921, 925 (9th Cir. 1987); *accord Caudill*, 999 F. 2d at 78-79; *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993). With FEHBA's preemption provision, and by delegating solely to OPM adjudicatory power over benefits disputes, Congress sought to further that goal. *See* H.R. Rep. No. 95-282, at 1, 4 (1977); *accord* S. Rep. No. 95-903, at 2 (1978), *reprinted in* 1978 U.S.C.C.A.N. 1412, 1413; H.R. Rep. No. 105-374, at 9, 16. In fact, Congress had even greater regard for uniformity in FEHBA than ERISA, because in FEHBA it nowhere included an insurance savings clause. Instead, state laws relating to "health insurance or plans" can be preempted. 5 U.S.C. § 8902(m)(1) (2000).

The operation of state law and its remedies is particularly offensive to FEHBA's uniformity objective because, in FEHBA (though seemingly not in ERISA), Congress expected uniformity not only in the benefits offered, but in the *rates* charged. *See* H.R. Rep. No. 105-374, at 9 (a goal of FEHBA's preemption provision was to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live"). But if state standards of medical reasonableness controlled, it could lead to benefits in one state being deemed medically necessary, but not so in another state – with the enrollees in both states nonetheless paying the same premium costs. "This situation would be fundamentally unfair to many federal employees covered by [the same FEHBA] contracts because enrollees in some states would pay higher premiums to cover services provided only to enrollees in other states." *Caudill*, 999 F.2d at 79; *see also* H.R. Rep. No. 95-282, at 4 (the operation of state law "would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States").

E. None of the issues under *Pegram v. Herdrich*, 530 U.S. 211 (2000), that cloud preemption under ERISA arise in the FEHBA context. Whereas *Pegram* raises the question whether a plan's denial of coverage based on lack of medical necessity constitutes fiduciary action (or, alternatively, is solely a matter for state law governance), the concept of fiduciary duties has no bearing under FEHBA. FEHBA contracts "do[] not fit the traditional trust category." *Christiansen v. Nat'l Savs. & Trust Co.*, 683 F.2d 520, 533 (D.C. Cir. 1982) (internal quotation marks omitted). "[T]he

FEHBA scheme [does] not create fiduciary or trust relationships, but create[s] 'third party beneficiary contracts.'" *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 44 (D.D.C. 1996) (quoting *Christiansen*, 683 F.2d at 530)).

Instead of having any fiduciary obligations, a FEHBA carrier's only duties to enrollees are those created by its contract with OPM, and the enrollees' only rights are those created by "the terms of the plan they subscribed to." *Christiansen*, 683 F.2d at 533. Because the federal government contract is the source of all duties and obligations – not state law or even any body of trust law – there should be no question that federal law exclusively governs the remedies of enrollees for grievances under the FEHBA program.

F. Congress's legislative activity further confirms that FEHBA creates a stronger case for federal jurisdiction and preemption than even ERISA. Whereas Congress has considered (though never passed legislation) amending ERISA's preemption clause to allow for the sort of state law cause of action that Respondents seek to pursue in these cases, FEHBA has not been the source of similar legislative interest. On only one occasion has Congress endeavored to create any sort of remedy for medical negligence in the FEHBA setting. And that proposal was to create an action for damages *against the federal government*, not any FEHBA carrier. *See* S. Bill 1052, 107th Cong., Amendment 850 (offered by Sen. Nickles).

Indeed, while Congress has been considering proposals to alter the scope of ERISA preemption to allow for additional state remedies (though, again, never enacting legislation to that effect), it has actually passed legislation expanding the scope of preemption under FEHBA. The 1998 amendment to FEHBA's preemption section "broaden[ed]" FEHBA's preemption provision, not only to ensure that contract terms relating to the "provision" of

benefits preempt state law, but also to rid the statute of an earlier requirement that only conflicting state law shall be preempted. H.R. Rep. No. 105-374, at 9; *see generally Botsford*, 314 F.3d at 393-94, 399 (summarizing 1998 amendment and its purposes). In FEHBA, Congress has readily, and recently, favored creating an exclusively federal field of regulation.

In short, the case for federal jurisdiction and preemption under ERISA of Respondents' claims is powerful and should result in the reversal of the Fifth Circuit's decision. The case under FEHBA is even more so and accordingly argues in favor of the Court limiting any holding against preemption that might be issued in this case solely to ERISA matters.

CONCLUSION

The Court should reverse the decision of the Fifth Circuit in these cases.

Respectfully submitted,

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In The
Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, et al.,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF *AMICUS CURIAE* OF THE AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether ERISA is intended to preempt remedial relief provided by state law when an HMO entity, acting through one or more of those in its employ or on its behalf, denies on a prospective basis a request for care and treatment as not medically necessary where the denial results from medical decision-making based upon the exercise of discretionary judgment.

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INTEREST OF THE *AMICUS CURIAE*

The American College of Legal Medicine ("ACLM") respectfully submits this brief as an *Amicus Curiae* pursuant to Rule 37 of the Rules of the Supreme Court of the United States, and submits it in each of these two consolidated cases. ACLM supports respondents in both cases. ACLM has received the consent of all parties to submit this brief pursuant to the applicable rules of this Court[1]

The ACLM has been in existence now for 44 years and is an educational, non-profit organization with nearly 1300 members. It is the only organization within the United States the majority of whose members possess degrees in medicine and in law. Its membership also consists of attorneys, physicians, nurses, those in health care administration, in government service and those who hold full time academic positions in health care and in health care law. It is also within the network of organizations worldwide whose members possess degrees, background and interest in the fields of medicine, forensic science and in law or jurisprudence.

The mission of the ACLM is to educate, train and advance dialogue and discussion for those who have a sustained interest in issues at the crossroads of law, medicine and health care delivery. This includes promoting the administration of justice and assisting jurists in deciding issues, such as the ones presented in these cases.

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[1] Petitioners and respondents have consented to the filing of this brief in letters filed with the clerk. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amicus* made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

By affirming the court below in both cases, this Court will incorporate within the fabric of federal jurisprudence a recognition that managed health care entities, i.e., HMOs or generically, those entities which provide or administer care through ERISA health plans, do, indeed, make medical decisions made prospectively based on discretionary judgment – as do other healthcare providers – for which these entities are held as accountable as all others who make medical decisions as to what care and treatment a patient should receive. In so doing as well, this Court will pronounce that remedial relief for such accountability remains venued in state and territorial forums, rather than in federal jurisdictions due to the constructs of ERISA.

The HMO market for providing and delivering medical care and treatment had its genesis at the federal level roughly three decades ago, when the HMO Act of 1973[2] was enacted by Congress. Neither this Act, nor ERISA,

[2] 42 U.S.C. §300c *et seq.*, more completely known as the Health Maintenance Organization and Resources Development Act of 1973, PL. 93-222. Nowhere in the legislative history (Senate Report No. 93-129) is there a suggestion to federalize medical decision-making made by those acting in the employ or on the behalf of HMOs. This is notwithstanding a specific section (pp. 3057-3059) on "Preemption of State Law." Additional evidence that Congress did not wish to interfere with states' rights in the area of health care is when there was stated, "It is not the intent of the [Senate Labor and Public Welfare] Committee that the Commission [on Quality of Health Care Assurance] engage in the setting of standards for, or the regulation of, the practice of medicine." *Id.* at 3074. Congress also emphasized that creation and enforcement of standards for health care and providers of that care should remain with the states. *Id.* at 3077. *See infra* n. 9 at 25-26.

through their legislative development or history, were *ever* intended to federalize state medical malpractice law. That is, Congress has never established a federal venue for the protection of health care plan beneficiaries, or enrollees, as patients from acts or omissions, resulting in harm, made by those schooled and trained in the practice of medicine, i.e., made through medical decision-making. Rather, this area, better known as being accountable for harm arising from failing to follow state established medical standards, comes within rights afforded consumers traditionally and historically left to states to create.

Further, while redress for medical decision-making has been made more complex due to the insertion of managed care entities into the medical decision-making process, medical decisions and those who make them fall outside of ERISA's preemptive reach.

Third, anyone who makes a medical decision prospectively in the care and treatment of plan beneficiaries is subject to the application of remedial relief provided by state and territorial law.

Fourth, and most importantly, the hallmark of a medical decision by a managed care plan is the application of discretionary judgment[3] based upon the personal characteristics of a patient. This judgment is guided by personal experience

[3] "A power or right conferred upon them by law of acting officially in certain circumstances according to their own judgment and conscience, uncontrolled by the judgment or conscience of others. " *Black's Law Dictionary* at 466 (6th ed. 1990) (as cited in McLean and Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 21 (2001)).

and accumulated medical knowledge.[4] Medical decision-making based upon discretion is what occurs before a determination of whether a certain course of care or treatment is deemed "medically necessary" within a health care plan.

Finally, a prospective decision about what is or is not a medically necessary treatment – for example, the use of a pharmaceutical or the length of stay within a hospital – as in the cases before the Court here, is a discretionary judgment about medical necessity rather than a determination incidental to a finding of whether a plan beneficiary is entitled to a benefit under the plan.

Culpae adnumerantur; veluti fi medicus curationem dereliquerit, male quempiam fecuerit aut perperam ei medicamentum dederit.[5]

---

[4] *Id.*

[5] "Again, if a surgeon operates on your slave, and then neglects altogether to attend to his cure, so that the slave dies in consequence, he is liable for his carelessness. Sometimes, too, unskillfulness is undistinguishable from carelessness – as where a surgeon kills your slave by operating upon him unskillfully, or by giving home wrong medicines." Institutes of Justinian (Book IV, Title III (Of the lex Aquila)) [*see* http://members.aol.com/hsauertieg/institutes/book4.htm], quoted in Sir William Blackstone, COMMENTARIES ON THE LAWS OF ENGLAND (1765-1769) (Book III: "Private Wrongs" (Chapter 8, n. 24-26) (matters found actionable as injuries affecting a man's health; cited in Buckner, F., OVERVIEW OF THE HISTORY OF MEDICAL MALPRACTICE at 50 (The Graduate Group-pub. (ISBN 0-938609-70-X (2002)).

ARGUMENT

I.

Introduction

The ACLM leaves it to the parties to advocate the merits of existing federal and state appellate cases that have defined what is considered a benefits decision or a medical treatment decision (*see* Zaremski, *Liability of Managed Care Organizations* (ch. 36) LEGAL MEDICINE (Sixth Edition) (Reed-Elsevier (2004)), and *Liability Exposure Facing Managed Care Organizations*, LEGAL MEDICINE (Fifth Edition) (ch. 46) 541-546 (Mosby (2001)); what is "quality" versus "quantity" of medical benefits (*see, e.g., Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995))[6]; what in the abstract is a pure administrative decision as opposed to identifying what is a pure treatment decision; and, most problematical, how to define what Justice Souter states in *Pegram* as a "mixed eligibility – treatment decision." *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000). The ACLM also leaves it to the parties to explain the preemptive reach of ERISA in the area where medical decision-making interfaces with granting or denying a benefit under a health plan, specifically the Court's treatment of complete, and ERISA, or defensive, preemption (*see e.g., Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996)).

---

[6] This decision has quickly established broad acceptance. See *Morreim, E.H., Special Issues in ERISA* at 268, n. 46 (listing some 33 federal and state cases), HOLDING HEALTH CARE ACCOUNTABLE (Oxford Univ. Press (2001)).

There is one necessary and critical predicate for answering whether, and when, ERISA preempts decisions made by health plan personnel. This "foundation," put simply, is, what does it mean to make a medical decision? The ACLM will provide this predicate as a springboard to the issues it addresses in this brief.

II.

DECISIONS

A. What is a Medical Decision?

The most cogent explanation to defining, pragmatically, medical decision-making is found in McLean and Richards at 35, *supra* n. 3 at 3. Therein, these authors state the following:

> The medical decision is the end result of a reiterative five-step intellectual process. The steps are:
>
> (1) evaluation of patient's complaints and history,
>
> (2) gathering physical and laboratory information,
>
> (3) making a medical decision,
>
> (4) reevaluation of the outcomes of those decisions, and
>
> (5) the collection of new information about the patient's altered condition.
>
> A treating physician gathers information by taking a history from a patient, the patient's family, or speaking with a fellow health care provider (Step 1). Alternatively, information can be

> extracted from the patient's medical record. This oral and written information is supplemented through the "laying of hands" on a patient (that is, physical examination) and through obtaining confirmatory laboratory studies (Step 2). Medical decision-making results from the physician's mental thought process as the first two steps are reviewed under the aegis of the physician's training and experience (Step 3). Such decisions are two-fold, encompassing a diagnosis and a treatment recommendation. While diagnosis is often seen as the key operational decision by physicians, from the patient's perspective, the treatment recommendation, or lack of one, is more critical. It is the remaking of these medical decisions that is the practice of medicine. Step 4, the evaluation of the outcome of the medical intervention, is the most critical because it closes the loop. If the outcome of treatment is not effective (that is, the patient does not improve), the medical decision must be re-evaluated. If the treatment is effective, the patient must be monitored to assure that the condition stays controlled. Step 5 begins the process again. Outcome evaluation may be based on follow-up lab tests, patient reports, and subsequent physical exams. These last two steps are most likely to be compromised in managed care, because they require the evaluation of what should be a "well" patient.

This translates into making discretionary judgments affecting a patient's care and treatment. In other words, a medical decision is a treatment, or, in the arena of an HMO, a decision of what care is medically necessary. This type of judgment in the medical field has been similarly defined as " . . . the formulation of observations and opinions based on . . . a highly technical knowledge base that is

distinctive to medicine as a profession. Two kinds of judging typically are involved . . . empirical judgments about what is going on . . . gathering diagnostic information about the patient and then combining these individualized observations with broader, scientific knowledge. . . . Second, . . . normative judgments about what ought to be done. Morreim, E.H., *Expertise and Tort Liability for Health Plans* at 107, 108, HOLDING HEALTH CARE ACCOUNTABLE (Oxford Univ. Press (2001)). A medical judgment is thus a choice about how to go about diagnosing and providing treatment for a patient's condition: given a patient's constellation of symptoms, what is the most appropriate medical response? *Pegram,* 530 U.S. at 228; *see Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., et al.,* 958 F. Supp. 1137, 1145 (E.D. Virginia (1997)) (the focus is on the soundness of a medical decision to grant or deny treatment made during the course of treatment).

Moreover, this decision-making paradigm does not constitute, as stated, for example, by Aetna (Br. at 34) the inclusion of "medical criteria" stated in a benefits plan, or incorporating certain "medical concepts" as eligibility criteria in a plan document, or even an interpretation of a health care contract (*see* U.S. Cham. Comm. Br. at 28). And, the "medical evidence," referred to in Aetna's brief (at 15) as arising from the *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003) decision, is similarly misplaced. With the latter, this Court chose not to invite into ERISA the 'treating physician rule' used to deliver Social Security disability benefits; the cases at bar do not seek to install the opinions of others *outside* the administration of ERISA plans as a basis for state-based remedial relief – rather, relief outside ERISA is sought based

upon discretionary judgments used to base medical decisions by those made *within* ERISA plan administration.

III.

DECISION-MAKERS

A. Who Makes a Medical Decision?

After arriving at a proper definition of what defines a medical, or treatment, decision, the next question to answer is, *who makes these decisions*? Clearly, a medical doctor is the ultimate decision-maker. The query is then raised whether these individuals as affiliated with an HMO, notably as medical directors, or those whose ultimate responsibility is to make medical decisions by approving or disapproving proposed care and treatment (what is medically necessary or not), is akin to those who may have more of a direct patient-physician relationship – like patients' treating caregivers. The answer is reasonably certain: yes.

A decision made by an HMO medical director is based upon medical judgment, arising from background, expertise and training in medicine. This judgment as to what is medically necessary in care or treatment by that personnel is no different than if it is made in a doctor's office or in a hospital corridor. *See e.g., State Board of Regulation for the Healing Arts v. Fallon*, 41 S.W. 3d 474, 476 (Mo. 2001), *cert. denied*, 2001 U.S. LEXIS 9987; *Murphy v. Board of Medical Examiners of the State of Arizona*, 190 Ariz. 441, 949 P.2d 530 (1980) (ERISA does not preempt disciplining medical directors of a third party administrator who makes medically necessary decisions); *Corporate Health Insurance, Inc., et. al., v. The Texas Department of Insurance*, 220 F.3d 641, 644-645 (2000) (" . . . Congress never intended to

preempt a state's power to regulate the quality of medicine;" (*id.* at 645)); *Isaac v. Seabury & Smith*, 2002 WL 1461710, *8 (S.D. Ind. 2002) [*Pegram*] focused on *decisions* . . . Regardless of who makes these decisions, they are all decisions which affect beneficiaries . . . we fail to see how . . . the nature of the enterprise – HMO or third party administrator – is a pertinent factor in determining whether ERISA completely occupies the field"). (emphasis in original); *see also* Zaremski, *HMOs, Accountability and the Death of ERISA Preemption*, 23 J. LEG. MED. 547, 557, 562 (2002). Consequently, treating physicians of plan beneficiaries are not the only ones who make decisions and identify care and treatment they may receive.

Further, while the cases above indicate a medical director of an HMO is a licensed practitioner subject to licensure requirements and discipline within the state for which (s)he is so licensed, a more problematic notion is whether those who assist physicians in providing patients with care, like a nurse, technician or assistant, also can, and do, make medical decisions. Logic dictates an affirmative response since the foundation for medical decisions, identified *supra* n. 3 at 3, and accompanying text, consist of data and information gathering as well as evaluating a patient's complaints and history. It is thus not inconceivable, particularly in a managed care setting, for these steps of the medical decision process to be undertaken by persons other than a physician as a medical director. Consequently, it lacks credence to assert that only a physician makes a medical decision (as asserted, for example, by Cigna (Cigna Br. at 32)) but those who gather the information upon which the decision is based, or who make decisions on their own, do not share in a measurable

way in the input upon which the ultimate decision is carried out. *A fortiori*, all those involved in this intellectual process, as defined above, necessarily make medical decisions. Consequently, the reference made to the *Pegram* Court about physician employees (*Id.* and at 33) is taken out of context to the issues presented here and out of step with the realities of modern day delivery of medical care.

Concomitantly, whether or not a category of an individual is a fiduciary under ERISA misses the point of whether that person is part of the medical decision-making process. Stated otherwise, that person can be a medical decision-maker whether or not acting in a fiduciary capacity under ERISA. *See* Cigna Br. at 36, n. 6, and U.S. Br. at 22 (a wrongful denial of benefits is actionable whether undertaken by a fiduciary or not). To be certain, nonetheless, those who contribute data or information to the physician are part of the decision-making process; not, as Cigna asserts, a " . . . trigger for what the statutes and regulators explicitly contemplate will be a fiduciary benefit determination process." *Id. But see Pegram*, 530 U.S. at 237 ("We hold that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA.")

IV.

STRUCTURE OF ENTITY WHICH MAKES DECISIONS

A. Capacity

Next, in what capacity does the entity exist on whose behalf a decision is made which responds to whether a requested treatment regimen is medically necessary or

not? In its case, Aetna admits being a third party administrator, and which asserts does not provide medical services (Aetna Br. at 6). Aetna is not the plan at issue either. The plan defines the scope of benefits, but not its implementation. (*See* Aetna Br. at 8) (Aetna is given discretionary authority for the determination of whether and to what extent eligible individuals and beneficiaries are entitled to coverage). Moreover, the Plan there provided for anti-inflammation medication without qualification; thus, the request for Vioxx was not a request for a benefit that was not provided in the first instance by the plan. *Id.* (prescription drugs are covered only as "indicated . . . for a medical condition as determined by Aetna." Less expensive drugs are covered first before a prescription for a more expensive medication is approved and allowed). *See id.* at 8-9. ("Vioxx is a covered plan benefit only if the member has already tried – or cannot try, because of allergy or contraindication – at least two of the fifteen other, similar drugs. . . . "). *See also* Morreim at 103, 123, *supra* at 8. (A request for a costlier drug, [such as Vioxx in *Aetna*], requires evaluating side effects of drugs previously administered, contraindications the patient's condition presents, how likely the requested drug will be to avoid side effects, and so forth. This constitutes making a medical judgment. An HMO " . . . should be held to a medical standard of care for the adequacy of the factual and medical basis on which they make their medical judgments." "When HMOs undertake this type activity, they should be liable for traditional tort claims of medical malpractice.") Aetna does, indeed, therefore provide a medical service.

From its record (Cigna Br. at 2), Cigna also acted as a third party administrator in order to administer plan benefits. Acting in this capacity, Cigna was not the plan

either as it did not determine which benefits were provided to *Calad*, only whether pursuant to a discharge protocol, Calad could receive the additional hospital stay she sought. *Id.* In other words, Cigna was making a judgment based on discretion – using medical decision-making whether the additional hospital stay was necessary or not. (*See Ouellette v. Christ Hospital*, 942 F. Supp. 1160 (S.D. Ohio 1996); *Bauman v. U.S. Healthcare, Inc.*, 1 F. Supp. 2d 420 (D.N.J. 1998); *aff'd.* as *In Re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 120 S. Ct. 2687 (2000); and *Plocica v. NYLCare of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999) (issue of length of hospital stay was deemed to be a quality of care matter not within the preemptive grasp of ERISA).

As Aetna and Cigna are not health plans, they do exercise judgment in determining whether medically necessary treatment is warranted, as this is synonymous with providing a medical service. Contrary to support they receive from one of their *amici*, there are no health plans here making medical necessity determinations. (*See* Assoc. Fed. Health Org. Br. at 3.)

B. Managed Care Entities are Unlike Indemnity Insurers in the "Fee for Service" Era

A final point here is a needed response to petitioners' assertions that they essentially provide coverage and merely pay claims, nothing more, and that coverage decisions referencing medical customs and standards constitute an interpretation of a contract (*see* U.S. Cham. Comm. Br. at 27-28). In this way, so HMOs assert, they are like indemnity insurers of days past (which HMOs supposedly replaced) and therefore they make the same

decisions whether or not to pay, through utilization review procedures, as did indemnity insurance companies that were never subject to state based relief in tort. *Id.* at 23. The difference, however, between now and then is striking. **HMOs make decisions on a *prospective* basis through their utilization review programs; indemnity insurers made decisions on a *retrospective* basis, i.e., whether or not to pay for treatment already provided.** If decisions are made on a prospective basis, then these types of decisions are the very same ones made countless times a day, every day, 365 days a year, by physicians and other healthcare providers nationwide. *See Long v. Great West Life & Annuity Ins. Co.,* 957 P.2d 823, 826-828 (Wyo. 1998); *Wickline v. California,* 192 Cal. App. 3d 1630, 1633-34 (Cal. Ct. App. 1986); *Fulton-DeKalb Hosp. Auth. v. Dawson,* 270 Ga. 376, 380 n. 5 (Ga. 1998); and Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures,* 103 YALE L.J. 1297, 1303 (1994). Moreover, another difference between the modern delivery and payment for health care treatment and the way it was done years ago is that if a traditional insurer denied or balked at payment, it did not deny access to care (the care, to reiterate, had already been given); if an HMO denies payment or erroneously denies a benefit, it does so before the care is rendered and before payment ever becomes an issue. In this regard too, causes of action, as here, that result from harm said to have occurred are not proximately caused from payment not forthcoming, but because the medical decision made did not meet accepted medical standards of care.

V.

APPLICATION OF DECISIONS TO THE CASES AT BAR

A. Applying "Discretionary Judgment" Standard

From respondent Davila's petition in the record, then, Aetna, not the language of the ERISA plan itself, determined which drugs were included in its formulary, or what would have to be done medically before receiving them. (*See* U.S. Br. at 1) (The agreement [between Aetna and Davila's employer] gave Aetna 'complete authority to review all claims for Covered Benefits', including '**discretionary authority**' to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under th(e) Group Agreement. Pet. App. at 102a." (emphasis supplied)). This included Aetna's "step program" as a predicate for additional pharmaceuticals if required for the failure of ones initially provided by it. This constitutes what this *Amicus* puts forth as the five steps to the intellectual process composing a medical decision-making, *supra* at 6-7: determining what drugs to initially provide and after which only then determining whether a different drug should be provided is no different than if the same intellectual process is carried out in a doctor's office or in a corridor of a hospital.

What about Ruby Calad? A decision was initially made, as part of the precertification process, to provide her a one-day hospital stay, given her type surgery (from the record it was a complex one – hysterectomy with rectal, bladder and vaginal repair). However, once the surgery was completed, her surgeon believed additional hospitalization

was required. The Cigna discharge nurse insisted upon the pre-certified one day of stay. Again, as with Davila, a *decision* was made, after considering and reevaluating the patient needs, completed surgery and what the physician requested, to not deviate from the one day stay. (*See* U.S. Br. at 4) (Under the Cigna plan, stays determined by pre-admission certification or **continued stay review**. (Cigna Opp. Mot. Remand App. 22) (emphasis supplied).

Additionally, from their respective petitions filed in the lower courts, neither claimant sought relief directly for *payment* of the benefit denied or for denial of a covered benefit (*see* U.S. Br. at 14 and AAHP-HIAA Br. at 12, 25); again, the predicate upon which the causes of action are seemingly based are decisions medically-based, resulting in *care and treatment* that should have been provided. To reiterate a point earlier made, the relief sought was not for payment for care already provided, but for care yet to have been rendered which resulted in claimed harm. As with Davis in the *Aetna* case not requesting Vioxx as a benefit of the plan, so, too, was Calad in *Cigna* not requesting an additional hospital stay as it was a defined benefit in her employer's plan. Neither Aetna nor Cigna made a decision to enforce the plan's prescribed algorithm for granting benefits; the decisions made and judgments used were not only ones a patient's treating physician could very well make, but were also predicated upon facts (choice of pharmaceutical/length of hospital stay) either not contemplated by plan benefits or not contemplated by the plan's prescribed algorithm.

Accordingly, the provision of the requested medical care and its application were not an ERISA plan. " . . . the ERISA plan is the employer's designation of preferred benefits, not the medical administrative structure used to

deliver the preferred benefits." McLean and Richards at 30, *supra* n. 3 at 3. This is consistent with when the *Pegram* Court said the word, 'plan' referred " . . . to a scheme decided upon in advance." *Pegram v. Herdrich*, 530 U.S. 211, 231; *see also* Peter D. Jacobson & Scott D. Pomfret, *Form, Function and Managed Care Tort: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUSTON L. REV. 985, 1050 (1998). Thus, a plan beneficiary's benefits based on the exercise of judgment are *not* the contractual rules by which an entity administering the plan operates. *See Isaac v. Seabury & Smith*, 2002 WL 1461710, *8 (S.D. Ind. (2002)).

VI.

STATE VERSUS FEDERAL FORUMS

A. Relief From Medical Decisions Resulting in Harm Rests in State Courts, Not With ERISA Remedies Enforced in Federal Courts

Justice Frankfurter once observed, " . . . in law also, doctrine is illuminated by history." *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring). Casting the lens of history upon American malpractice jurisprudence reveals that physicians, once hailed as "captains of the ship" regarding medical decision-making, have been joined on the captain's bridge by hospitals, health insurance companies and, now, HMOs. More importantly, history demonstrates that states have repeatedly responded to the sharing of physician control over decision-making by extending liability to those parties that have been the recipients of decisional authority.

Buckner, in his work, OVERVIEW OF THE HISTORY OF MEDICAL MALPRACTICE, *supra* n. 5 at 4, provides, too, an exhaustive treatment of the history of medical malpractice over literally recent centuries – even inclusive of Blackstone's reference to harm committed by physicians and surgeons during the era of the Roman empire referenced in Latin atop the "Argument" section of this brief (*supra also* at 4). However, the importance of his (Buckner's) work is a beacon to illuminate that of which Justice Frankfurter spoke: using history as a base, having the law craft solutions for acts or omissions that reflect the wrongs from practicing medicine or providing that care – in other words, applying ***accountability*** to settings in which medical decisions are made. As these settings change, or evolve, so, too, must the law's recognition and enforcement of those to be held accountable.

(This development of) "accountability" is the watchword that best suggests the focus for confronting the realities of how medical care is now provided. One scholar put it this way: " . . . the law addressing patients' adverse outcomes in the context of health care should be and reasonably can be better attuned to the profound changes in the ways health care is now . . . delivered." Morreim at 158, *supra* at 8. For example, and as opposed to Cigna's assertion (Cigna Br. at 39), modern medicine involves well-trained individuals who do not necessarily have direct contact with the patient and who are not the patient's treating physician. Buckner at 135; *see Darling v. Charleston Community Hospital*, 33 Ill. 2d 326 (1965) (hospitals liable for institutional negligence); *Jones v. Chicago HMO Ltd. of Illinois*, 191 Ill. 2d 278 (2000) (an HMO may be held liable for institutional negligence) (HMOs undertake an expansive role in arranging for and providing drugs

and health care services to its members); *Shannon v. McNulty*, 718 A. 2d 828, 835-36 (Pa. Super. Ct. (1998)) (HMOs consist of an amalgam of individuals who play various roles in order to provide comprehensive health care services to their members); *Petrovich v. Share Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 28 (1999) (HMOs act as health care providers); and *Official Lists Current Amicus Briefs of Labor Department on Medical Malpractice*, 68 U.S.L.W. 2249-50 (November 2, 1999) (HMOs wear "three different hats", one of which is "medical provider").

The period between *Darling* and *Jones* was 35 years, but the Illinois Supreme Court extended institutional accountability from hospitals to HMOs in its state courts over that time span. Now, this Court is given the opportunity to declare once and for all what has been menacing state and, particularly, lower federal courts for an equally imposing time, and that is, that ERISA's preemptive reach should not, and does not, extend to medical decisions based on discretionary judgment made on a prospective basis by those who provide or administer healthcare pursuant to, or on behalf of, ERISA health plans. The evolution of state-based remedies for such decisions, and, concurrently, ERISA preemption analysis now must lead as well to where such decisions envelop the province of state law in state courts; not remedial relief found in ERISA. *See Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. at 1149) (Common law medical malpractice is quintessentially the province of state authority. There is simply no reason to believe that Congress – by enacting a statement [ERISA] designed to protect the interests of workers in their benefit plans – intended to remove the long-standing protection against

medical negligence afforded by state malpractice law; *see also infra* n. 9, 11 at 25-28.)

Furthermore, denying a request for care and treatment as not medically necessary can be viewed as a denial of a benefit but it *is* in essence making a medical decision *if* discretionary judgment resulting in the denial is used. These two notions [denying care and making a medical decision] are " . . . practically inextricable from one another." (*Pegram*, 530 U.S. at 229). This description also more accurately describes what occurs in administering a health plan.[7] To deny the clarity of what has just been stated is to deny (1) the need for medical directors and medically trained personnel in the employ of HMOs, and (2) to deny the purpose for which Congress sought creation of HMOs in the early 1970s. *See Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733, 735 (C.D. Cal. (1989)). Thus, so long as discretionary judgment is embedded in decisions made prospectively resulting in a denial of requested medically necessary treatment, remedial relief for any harm arising therefrom must, as it has, remain with the states for adjudication.

Finally, this Court has spoken using by reference, the "mixed eligibility/treatment" decision (*Pegram*, 530 U.S. at 228). These words should no longer be the terminology used by this Court as they are misleading and their connotation inappropriate. More accurate verbiage is that medical decisions made prospectively based on discretionary judgment that conclude in a denial of requested care is

[7] Morreim describes it as combining resources and expertise. Morreim, *supra* n. 6, at 142, 148.

a denial of a request for medically necessary treatment. This translates to a blending of medical care and administrative functions which are neither related to a plan nor completely preempted by ERISA.[8]

VII.

HEALTH CARE COSTS

A. State Based Remedies for Medical Decision-Making Have Not Increased Health Care Costs or Costs To Provide Benefits.

A "footnote" to the positions advanced in this brief. To say, as put forth by petitioners, that imposing state medical malpractice remedies as a replacement for relief under ERISA for adverse benefit decisions would drive up costs of health care is totally disingenuous. To be sure, the debate has not concluded on what is the principal force behind the malpractice crises said to have existed since the late 1960s (*see* MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, A study submitted by the Subcommittee on Executive Reorganization (Sen. A. Ribicoff, Chr.) to the Committee on Government Operations, United States Senate (91st Congress, 1st Session (November 20, 1969)), and MEDICAL MALPRACTICE: (Report of the Secretary's Commission on Medical Malpractice) (DHEW Publ. No. (0S) 73-88 (January 16, 1973)) and now found in the first decade of this century. However, the literature is rich with discussions that medical malpractice litigation has not been the genesis for huge spikes in malpractice insurance found to have occurred now and

[8] *See Id.*

in decades past. U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702* (Washington, D.C., June 27, 2003), and U.S. General Accounting Office, *Medical Malpractice*: *Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (Washington, D.C., August 8, 2003). *See* Hunter and Doroshow, *Premium Deceit: The Failure of Tort Reform To Cut Insurance Prices*, Center for Justice and Democracy (New York, New York (2002)), and Statement of Richard J. Hillman and Kathryn G. Allen, *Medical Malpractice Insurance-Multiple Factors Have Contributed to Premium Rate Insurance*, Subcommittee on Wellness and Human Rights, Committee on Government Reform, U.S. House of Representatives (October 1, 2003 (GAO-04-128T)). Moreover, the asserted linkage between state medical malpractice litigation and the costs of health care is tenuous too. *Id. See Limiting Tort Liability for Medical Malpractice at 1, 6*, ECONOMIC AND BUDGET ISSUE BRIEF (Congressional Budget Office (January 8, 2004)) (malpractice costs represents less than 2 per cent of overall health care spending).

It is claimed as well (Cigna Br. 48) that the mere threat of costly medical malpractice litigation encourages "defensive medicine". In fact, the government's own study, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, *id.* at 6, states, " . . . the overall prevalence and costs of such [defensive medicine] practices have not been reliably measured."

All of the above notwithstanding, petitioners' logic that importing state tort medical malpractice relief into employee health benefit plan administration would seriously affect employee benefits as it [allegedly] has the cost of medical care (Cigna Br. at 49, Aetna Br. at 17, 41, and

U.S. Cham. Comm. Br. at 24-25.) is also seriously flawed. Because the *sine qua non* of benefit plan administration in this day and age of HMOs is to make, where they are made, discretionary judgments prospectively about what care and treatment a plan beneficiary should be given or allowed.

The phrase, "he who lives in glass houses should not throw stones", has considerable force in this regard. That is to say, HMOs have taken it upon themselves, as part of being in their business, to interject discretionary judgments prospectively made regarding the care and treatment to be provided a patient as part of administering, delivering and providing that care. This decision-making has consequences if it does not meet a standard of applicable care; the *quid pro quo* for such consequences is, to reiterate, accountability – again to reiterate, the very same accountability imposed upon physicians and others who deliver and provide healthcare by making or contributing to medical decisions. And to camouflage such decisions as simply a denial of a benefit or simply as nothing more than paying a claim, as petitioners and their *amici* have done, is to avoid the realities of how health care is provided in this country today.

If HMOs are the genesis for their own accountability due to the medical decisions their personnel make, it defies logic to then say that a state tort malpractice system will be the culprit for increasing the cost of providing a benefit under a health plan; or, perhaps, are the managed care entities in the cases at bar asserting that they agree to be held as accountable for the same decisions as other health care providers make, but only in a legal venue of their own liking which is not state-based and which provides them with limited exposure? The latter, if

true, would cause consumers and health care practitioners alike to align in dramatic revolt against this HMO position; this stance would also prove costly for the legal system since adjudicating accountability for medical decision-making of the same variety would have to be based in two forums: federal for HMOs and state for all others.

B. Accountability, Preemption and State Based Relief

Because ERISA was never intended to federalize medical malpractice law, accountability for harm resulting from medical decisions based on discretionary judgment on a prospective basis must continue to rest in state and territorial venues – as it has for over 200 years. Buckner at 54, 154, *supra* at 4, 18 (citing to 1794, Connecticut 2 Root 90. Jesse Root, *Reports of Cases Adjudged with the Superior Court and in the Supreme Court of Errors in the State of Connecticut*, 1793-1798 n. p., 1802, Vol. II, pp. 90-92 as contained in Burns, *Malpractice Suits in American Medicine Before the Civil War*, BULLETIN OF THE HISTORY OF MEDICINE, 43:41 at 54-56 (1969)).

Finally, there are assertions advanced in the cases at bar that ERISA's remedial provision is exclusive, and that exclusivity gives rise to preemption of any state tort cause of action based on medical decision-making, and certainly to ones Congress forgot to incorporate expressly. (Aetna Br. at 19, 20, and 40; *see also Mutual Life Ins. v. Russell*, 473 U.S. 134, 147 (1985)). Even one of petitioners' *amici* advocates that state negligence claims aimed at medical necessity decisions constitute a frontal attack on regulating ERISA plans. *See* Assoc. Fed. Health Orgs. Br. at 9.

If these assertions all were true, then no discretionary judgments prospectively rendered and by the persons in whose capacities are similarly described (in this brief) could ever give rise to a state cause of action for asserted breach of state established standards of medical care. These positions would fly in the face of much decades-old jurisprudence that standards for medical care and treatment are state – based (*see*, Epstein, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTHCARE? 365 (1967)), which has been well recognized and acknowledged as such by Congress, certainly at least from before passage of the HMO Act of 1973.[9] It follows that state-based

[9] *See* Senate Committee on Labor and Public Welfare Report No. 93-129 on The Health Maintenance Organization and Resources Act of 1973 (S. 14) at 3077 (" . . . that states should be given the opportunity to develop health care standards . . . An added factor in the Committee's decision to encourage states to develop their own standards is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development and health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards . . . The Committee also feels that states, through their agencies, should be given the opportunity to enforce such standards . . . The concept of permitting the state agencies to develop their own standards and to enforce them . . . is in keeping with the overall philosophy of the Committee." See *supra* n. 2 at 2.

This notion of states being the proper forum for standards and medical decision-making can also be seen in remedy sections of various patients' bills of right ("PBOR") crafted and passed by one Congressional chamber or another since October 1999, through bipartisan leadership of, among others, the Hon. Charlie Norwood (R.-Ga.) and Hon. John Dingell (D.-Mich.) in the House (Section 302 in HR 2723, succeeded by HR 2990, which passed overwhelmingly in the House in October 1999) (*see* Zaremski, *Liability Exposure Facing Managed Care Organizations*, LEGAL MEDICINE (Fifth Edition) at 545-549 (Mosby Inc. (2001)) and the Hon. Edward M. Kennedy (D.-Mass.), Hon. John Edwards (D.-N.C.) and Hon. John McCain (R.-Az.) in the Senate (*see*,

(Continued on following page)

remedies are the appropriate Damoclean swords to insure that plan participants receive appropriate levels of medical care. These remedies are certainly far from being "crude" (Aetna Br. at 44) or unnecessary to protect plan beneficiaries from harm that results from medical decisions made by HMOs. (AAHP-HIAA Br. at 5) ("There is no reason to believe that such [state tort litigation] suits are

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e.g., S. 1052, which passed the Senate 59-36 on June 29, 2001 (107th Congress)). Contrary to the assertion put forth by Aetna (Br. at 42, n. 23), both the House *and* the Senate have thus passed versions of PBORs containing provisions to remove the ERISA shield and permit cases regarding medically reviewable issues to be brought in state court), not " . . . exclusively federal".) *Id.* Parenthetically, the amendment to H.R. 2563 on liability, as referenced by Aetna, passed the House by a 218-213 margin, so the passage of this amendment was anything but overwhelming. As amended, the bill would have permitted an injured patient to bring a cause of action against a health plan in state court but would impose certain standards, for example, if an independent medical reviewer upheld a determination by a health plan to deny a benefit, it would create a presumption, rebuttable only by clear and convincing evidence, that the health plan exercised ordinary care in making the determination. In this (108th) Congress, S. 1945 would amend ERISA to remove the ERISA shield and permit patients injured by decisions made by their employer-sponsored health maintenance organizations to bring cases regarding medically reviewable issues in state court under state tort laws. H.R. 596 would amend ERISA to exclude from preemption state causes of action to enforce determination under group health plans based on medical necessity. S. 1945 was referred to the Senate Health, Education, Labor and Services Committee. H.R. 596 was referred to the House Education and the Workforce Committee.

See also H.R. 5 ("Health Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003) which passed the House in the current Congress. Section 13 of the bill, at 26, states as follows: **"It is the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate."** (emphasis supplied)

necessary to protect plan beneficiaries.")[10] What would be crude is, for example, the government's position that there are circumstances where harm could result from treatment being denied, but the beneficiary would be denied [state based] relief except for the loss of the benefit denied provided by ERISA. U.S. Br. at 25-26.

VIII.

CONCLUSION

While a denial of medically necessary treatment concludes in denying requested care and treatment, e.g., denying a benefit, the essential premise put forth by this *Amicus* is that determining medically necessary care on a prospective basis is not in any fashion incidental to denying a plan benefit. **Denying a benefit prospectively using discretion in the administration of a health plan care *is* requested care and treatment denied.** Consonant with this is that HMOs employ suitably trained personnel charged with making these decisions. And so long as these individuals exercise discretionary judgment, neither remedial relief provided plan beneficiaries by ERISA is implicated[11] nor are state remedies duplicative or supplemental of what Congress intended ERISA to provide.

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[10] Yet, apparently the government does not concede this position when recognizing the existence of decisional law allowing for HMOs to be vicariously liable for decisions made by their physicians. U.S. Br. at 29.

[11] This would be in line with commentators favoring a limited reach of ERISA's preemptive arm. *See* Jacobson and Pomfret at 985, 994, 1048, *supra* at 17; *see also Ceminara, Protecting Participants in and Beneficiaries of ERISA – Governed Managed Health Care Plans,* 29 UNIV. OF MEMPHIS LAW REV. 317-361 (1999); *Koutoulogenis, The*

(Continued on following page)

More importantly, the day has finally arrived for this Court to pronounce that medical decisions in the form of what is medically necessary made on a prospective basis to determine care and treatment for a plan beneficiary by HMO personnel are no different than if those decisions are made by the plan beneficiary's treating physician or by someone medically trained who provides care, through judgments made, to a patient indirectly, such as by a hospital based health care practitioner or hospital employee. Just as healthcare providers indisputably have been subject to accountability under state laws for making erroneous medical necessity decisions that deny patients access to a reasonable standard of care, so should HMOs be similarly accountable. By making such a declaration, this Court will recognize that state courts have historically extended malpractice liability to those parties who are involved in the medical decision-making process. As a matter of public policy, this Court should not thwart that course, which states have undertaken within the purview of their police powers over the medical profession. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 655 (1995) ("'. . . the historic police powers of the States were not to be superceded by the Federal Act unless there was the clear and manifest purpose of Congress'.") Furthermore, the deliberate footprints created by malpractice jurisprudence demonstrates

Invisible Man: a Call to Empower Individual Participants and Beneficiaries against Fiduciary Breaches in ERISA Plans, 34 TORT & INS. LAW J. 131-166 (1998); and Wethly, *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.: Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp*, 37 BOSTON COLL. L. REV. 813-860 (1996).

that Congress, in passing ERISA, did not intend to stop the states in their paths simply by remaining silent on the issues. Only a clearly expressed congressional intent can impede state-adjustment of malpractice liability's scope when that adjustment is made in an effort to hold accountable those parties who steer the course of medical decision-making.

For the foregoing reasons, the judgments of the Fifth Circuit should be affirmed.[12]

Respectfully submitted,

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[12] By doing this, this Court will not need to deviate from its position that it is not in a position to differentiate one type HMO model from another (*Pegram*, 530 U.S. at 222; *see also* Aetna Br. at 33, n. 16). HMO structures, like network or group models, can remain separate *except* insofar as when personnel from each makes a medical decision prospectively as to what care and treatment is medically necessary based upon discretionary judgment – in such situations the structures become irrelevant.

FOR ARGUMENT

Nos. 02-1845 and 03-83

Supreme Court, U.S.
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In The
Supreme Court of the United States

AETNA HEALTH INC., FKA AETNA U.S. HEALTHCARE INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION,

Petitioner,

v.

RUBY R. CALAD, ET AL.,

Respondent.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF FOR *AMICUS CURIAE* SENATORS EDWARD M. KENNEDY, JOHN McCAIN, BOB GRAHAM AND REPRESENTATIVES JOHN D. DINGELL, CHARLIE NORWOOD, GEORGE MILLER, AND CHARLES B. RANGEL IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether ERISA is intended to preempt malpractice jurisprudence, provided by state law when an HMO entity, acting through one or more of those in its employ or on its behalf, denies a request for care and treatment as not medically necessary where the denial results from medical decision-making based upon the exercise of discretionary judgment.

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INTEREST OF *AMICI CURIAE*[1]

Amici United States Senators and Representatives are primarily members of Congress who were serving in Congress at the time of the adoption of the Employee Retirement Income Security Act (hereinafter "ERISA" or "the Act") and the Health Maintenance Organization Act (hereinafter "HMO Act"), serve on committees of jurisdiction over ERISA or health care, and/or have sponsored Patients' Bill of Rights legislation to provide a federal and state system of guaranteed rights and responsibilities to the over 200 million American workers and their families who are covered by ERISA health plans or other health insurance.

Amici have a strong interest in providing the Court with information regarding Congress' intent at the time of enactment of ERISA and thereafter. Recent legislative debate over enactment of a federal Patients' Bill of Rights was expressly focused on the issue of meaningful causes of action and redress under ERISA as well as traditional state jurisdiction over health care and torts. Although Congress has yet to enact a federal Patients' Bill of Rights, an overwhelming majority of the members of Congress, on a bipartisan basis, have supported the principle that state standards which bring into focus accountability by those

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[1] Petitioners and Respondents have consented to the filing of this brief in letters filed with the clerk. No counsel for a party authored this brief in whole or in part. Members of Congress made a monetary contribution to the printing of this brief.

whose judgments decide what is medically necessary care and treatment on an on-going basis must not be altered by federal law. *Amici* also do not believe that ERISA intended to displace state malpractice laws, and do not believe such laws conflict with the purposes or structure of ERISA.

SUMMARY OF THE ARGUMENT

During legislative development and consideration of ERISA, Congress was predominantly focused on establishing minimum standards to protect the pension promises made to millions of workers and their families. Congress did not intend for ERISA's pension standards to be interpreted by the courts as preempting state health care laws. Congress intended to regulate health care through legislation other than ERISA. Although ERISA was amended in conference to expand its provision on preemption of state laws, Congress had no intention of preempting a wide swath of state laws such as state health care laws or malpractice laws. There is no legislative history in ERISA, the HMO Act, or any other laws that indicate that Congress intended to preempt state health care regulation or malpractice laws. During recent consideration of legislation to enact a Patients' Bill of Rights, a bipartisan majority of Congress has indicated its intention to establish minimum health insurance patient protection standards apart from ERISA and to make clear that insurers and health maintenance organizations should be accountable for their discretionary medical decisions, including mixed eligibility and treatment decisions, under state law. Such

legislative efforts are not the result of any need to reform what was primarily a pension bill – but are the result of an accumulation of court decisions which have incorrectly construed ERISA as providing a shield for medical decision-makers.

ARGUMENT

I.

ERISA WAS ENACTED TO PROTECT PARTICIPANTS AND BENEFICIARIES ELIGIBLE UNDER EMPLOYEE BENEFIT PLANS

At its core, ERISA was designed to provide basic minimum rights to workers regarding their pension plans. The Act was the result of almost 10 years of legislative consideration by the Congress. The impetus for the bill was a series of bankruptcies by a number of employers. Under these bankruptcies, tens of thousands of older workers lost their jobs and could not retire with their pensions. While their employers had promised pensions to these workers, they had failed to fund the pension plans. In light of this crisis, the debate in Congress focused on developing a system for requiring employers to vest long-service employees with promised benefits and fund pension plans over a reasonable period of time. The debate was an urgent one. At the time, of the tens of thousands of pension plans then in existence, fewer than 20% were funded. *See* 120 Cong. Rec. 29,933 *et seq.* (1974) (statement of Sen. Javits (R-NY)).

On September 2, 1974, thirty years ago this year, Congress enacted ERISA. The Congressional Findings and

Declaration of Policy of the Act lay out the legislation's purposes and goals:

> The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial, that the operational scope and economic impact of such plans is increasingly interstate, that the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . and it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that *minimum standards be provided assuring the equitable character of such plans and their financial soundness.*

29 U.S.C. § 1001(a) (2003) (emphasis added). What Congress meant by these "minimum standards" becomes clear with an examination of the Act's legislative history.

The legislative history demonstrates a clear congressional intent for ERISA to provide basic rights to working men and women as pension plan participants and beneficiaries. Congress' focus was on creating minimum standards by which the pension plan promises of employers would be measured and enforced. During House floor debate on ERISA, Rep. Perkins (D-KY), a lead cosponsor of the bill, explained the legislation's purpose: "We have *basic minimum pension rights* written into this bill which should have been enacted many, many years ago *to protect the rights of working people*." 120 Cong. Rec. 29,192 (1974) (statement of Rep. Perkins) (emphasis added). The Senate debate contains similar statements. Senator Williams (D-NJ), one of the bill sponsors, opened his floor statement by stating, ". . . I am happy to report that after long and

numerous meetings of the conferees of HR 2, we are able to bring before the Senate a conference agreement which has been unanimously adopted, and which, for the first time, *will safeguard the pension expectations of American workers*." 120 Cong. Rec. 29,928 (1974) (statement of Sen. Williams) (emphasis added). Senator Javits, the lead sponsor of the Senate bill, highlighted that the bill ". . . represents *a series of fundamental guarantees* made to every American worker – guarantees that will secure for millions of Americans the expectation of a decent retirement income in combination with social security. These guarantees are *nothing less than a pension 'bill of rights'* to which every worker – regardless of his occupation, salary or status – is entitled." 120 Cong. Rec. 29,933 (1974) (statement of Sen. Javits) (emphasis added).

In enacting ERISA, Congress believed it was providing a series of federal pension rights to workers and their families. Its focus was entirely on establishing new minimum protections, not eliminating a wide swath of long-standing traditional state protections.

II.

ERISA CONTAINS A COMPREHENSIVE SCHEME OF RIGHTS AND RESPONSIBILITIES FOR PENSION PLANS, BUT NOT FOR HEALTH PLANS AND OTHER TYPES OF EMPLOYEE BENEFITS.

As the Court has noted in several of its decisions, ERISA contains a comprehensive system of rights and responsibilities for certain types of employee benefit plans – namely, pension plans. *See, e.g., Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d 39 (1987); *New York State Conference of Blue Cross & Blue*

Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed. 2d 695 (1995). ERISA does not provide such a comprehensive scheme for health plans and other types of non-pension employee benefits.

In fact, its very title reveals its focus on retirement and pensions. This pension focus was no accident. At the time of enactment, adoption of a national health care system appeared imminent. President Nixon had proposed a national mandated employer-based system, and leading Democrats supported a national government system. *See* S. 1422, 93rd Cong., 1st Sess. (1973) (introduced by Sen. Kennedy (D-MA)); H.R. 1 and H.R. 33, 93rd Cong., 1st Sess. (1973) (introduced by Reps. Ullman (D-OR) and Dingell (D-MI), respectively). In other words, while ERISA presented a comprehensive scheme for regulating pension plans, Congress had other efforts in mind for grappling with the provision of health care – efforts which continue to this day.

The pension focus is evident throughout the Act. The main title of ERISA, Title I, contains the following five parts: 1) reporting and disclosure, 2) participation and vesting, 3) funding, 4) fiduciary responsibility, and 5) administration and enforcement. 29 U.S.C. § 1001 *et seq.* (2003). Each of these parts provides detailed rules to which pension plans must comply. Pension plans must annually file detailed financial disclosure forms with the Internal Revenue Service. 29 U.S.C. §§ 1021-1031 (2003). Pension plans must provide coverage to specific categories of employees, vest their right to benefits after a specific period of time, accrue benefits in specific form, and pay benefits at specific times. 29 U.S.C. §§ 1051-1061 (2003). Pension plans must comply with detailed rules for funding. 29 U.S.C. §§ 1081-1086 (2003). Employers must

adhere to a strict scheme of fiduciary responsibility for the management of all pension fund monies. 29 U.S.C. §§ 1101-1114 (2003). And participants, beneficiaries, employers, plans and the Secretary of Labor have elaborated rights and responsibilities to achieve compliance with the Act. 29 U.S.C. §§ 1131-1147 (2003).

In contrast to this extensive regulatory scheme for pension plans, non-pension benefit plans are only subject to three of the five parts of ERISA Title I – reporting and disclosure, fiduciary responsibility, and administration and enforcement – and even then in abbreviated form. For instance, welfare plans such as health insurance are subject only to simplified reporting requirements, if any. In a provision which plainly underscores Congress' pension focus, the Act leaves it to the Secretary of Labor to either exempt welfare benefit plans entirely from the reporting and disclosure requirements of Title I or create simplified reporting regulations for these non-pension plans. 29 U.S.C. § 1024(a)(3) (2003). And as the Court has noted, aspects of the fiduciary responsibility rules also may be construed as inapplicable since the primary functions of non-pension plan fiduciaries do not involve discretionary authority or control respecting management of the plan or its assets. *Pegram v. Herdrich*, 530 U.S. 211, 231-232, 120 S.Ct. 2143, 2155-2156, 147 L.Ed. 2d 164, 182-183 (2000); *see also* 29 U.S.C. § 1002(21) (2003) (ERISA's definition of a fiduciary).

Even ERISA's causes of action primarily make sense in the context of pension benefits. In a pension plan, an employer promises to provide a retirement benefit to certain employees upon reaching a specific age or termination of employment and based on a predetermined formula or contribution rate. The situations in which a cause of

action might arise most likely include failure to pay promised benefits, a dispute over the amount of benefits, or allegations of abuse of promised funds. Each of these causes of action neatly fits under ERISA's multi-part enforcement test. 29 U.S.C. § 1132(a) (2003). In contrast, most health benefit disputes center on whether requested or received treatment was "medically necessary," a concept not defined by ERISA or subject to any ERISA standards. Thus, although health plan payment procedures constitute plan administration, accountability for the quality of medical judgment historically has been a matter of state law.

The legislative history also confirms Congress' focus on pensions. The Conference Report to ERISA opens by stating that "[t]he committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (HR 2) *to provide for pension reform*, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows: . . ." H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 1 (1974) (emphasis added). The floor statement of Rep. Perkins, a sponsor of the bill, stated ". . . to summarize what is being done today let me state – after years of study and investigation, hearings and debate, after endless hours of work, *pension reform legislation* of an historic character is almost complete." 120 Cong. Rec. 29,192 (1974) (statement of Rep. Perkins) (emphasis added).

As previously noted, the Senate debate contains similar statements. Senator Williams, one of the bill sponsors, explained that ERISA was ". . . the outgrowth of a 3-year in-depth study of the *private pension system* . . ." 120 Cong. Rec. 29,928 (1974) (statement of Sen. Williams)

(emphasis added). Further, Senator Javits, the lead sponsor of the Senate bill highlighted that ". . . [f]or *the pension reform bill* is the greatest development in the life of the American worker since social security. For the first time in our history most workers will be able truly to retire at retirement age and to live decently on their Social Security, and private pensions." 120 Cong. Rec. 29,933 (1974) (statement of Sen. Javits) (emphasis added). In other words, Senators and Representatives repeatedly referred to ERISA as a *pension* reform bill – to the exclusion of a health care reform bill or even a general employee benefits reform bill.

In fact, other than the definition of an employee welfare benefit plan, at the time of enactment, the statute and legislative history were effectively silent on regulation of health care. *See* 29 U.S.C. § 1002(1) (2003) (ERISA's definition of a welfare benefit plan). As will be seen, Congress intended ERISA to focus on the private pension system while other legislation would deal with health care reform. The enactment of ERISA should not be viewed in a legislative vacuum – but in the context of surrounding legislative activity.

III.

CONGRESS INTENDED TO REGULATE HEALTH CARE THROUGH LEGISLATION OTHER THAN ERISA.

The legislative history of ERISA is almost completely silent on Congress' intent with respect to health care regulation and particularly on issues related to medical treatment decisions, including accountability and liability for harm arising from such decisions. In large part this was due to the fact that Congress intended to regulate

health care through other legislation. And in the case of the Health Maintenance Organization Act of 1973 ("HMO Act"), enacted during the same Congress, it did so. Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified at 42 U.S.C. § 300e (2003)).

The managed care industry was in its infancy in the early 1970s. Accordingly, there was no suggestion that Congress should have considered the shield being asserted to preempt state-based relief for HMO-related actions today. State-based relief issues largely developed over the last decade or so through court-made decisions. *See e.g., Morreim, E.H., Special Issues in ERISA,* HOLDING HEALTH CARE ACCOUNTABLE at 268, n. 46 (Oxford Univ. Press (2001)) (listing roughly 33 federal and state cases); *see also* Zaremski, *Liability of Managed Care Organizations*, LEGAL MEDICINE Ch. 36 (6th Ed. (2004)). Employers generally contracted with health insurance companies that paid on a retrospective basis for covered care. State-licensed health care providers provided treatment under state standards of medical care. *See, e.g., Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

The HMO Act was enacted to provide federal support for the development of HMOs. This law contains a series of provisions which define HMOs and their elements – including covered benefits, assumption of risk, accessibility of services, health care personnel, and consumer role – authorize funding for their development, and create a Commission on Quality Health Care Assurance. 42 U.S.C. § 300e et seq. (2003). The main legislative history for the HMO Act is contained in the Senate Report by the Committee on Labor and Public Welfare. S. Rep. No. 129, 93rd Cong., 1st Sess. (1973). The report contains a section on "Preemption of State Law." *Id.* at 26-27. Nowhere is there

any discussion of federalizing medical or mixed eligibility and treatment decisions made by HMOs comparable to the cases at hand. In the context of its discussion of establishing a Commission on Quality Health Care Assurance, the Committee stated, "[i]t is not the intent of the Committee that the Commission engage in the setting of standards for, or the regulation of, the practice of medicine." *Id.* at 43. The Committee also emphasized that there must be a development of local mechanisms for monitoring and improving the quality of health care services, both in and out of health care assurance systems since local disease patterns and treatment methodologies differ. *Id.* Additionally, the report states, again in connection with a commission on quality health care, that states should be given the opportunity to develop health care standards. *Id.* at 46. One of the reasons was that experience in the medical field indicated that the closer the responsibility for standards development and health care regulation is to the actual provider of care, the more likely the provider is to become involved in the development and setting of standards. The Committee concluded in this regard by saying, "[t]he concept of permitting the state [agencies] to develop their own standards and to enforce them . . . is in keeping with the overall philosophy of the Committee." *Id.*

The HMO Act did not, and did not intend to, federalize standards of medical care or the practice of medicine – the foundation of which is to make medical decisions. Congress has not undertaken passage of any legislation since that time which would vary from the Senate report.

IV.

THERE IS NO LEGISLATIVE HISTORY IN ERISA OR THE HMO ACT THAT CONGRESS INTENDED TO PREEMPT STATE HEALTH CARE REGULATION OR MEDICAL MALPRACTICE LAWS.

There is no legislative history for ERISA, the HMO Act, or any other legislation that provides guidance to suggest, as Petitioners seem to do in their briefs, that Congress intended to shield health benefit plans or their intermediaries from consequences arising from decisions made by those administering the plans affecting the medical care and treatment provided plan participants and beneficiaries (including under the guise of making payments for care or of a plan benefit determination). Those seeking reversal of the court's decisions below seek to stake claim to the position that our silence meant we wanted such a shield to arise in 1974. We failed to speak in 1974 because it was never our intent to have ERISA apply to issues as now before this Court.

As the Court has held, "[t]he question whether a certain state action is pre-empted by federal law is one of congressional intent" and on the ". . . assumption that the historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress." *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45, 107 S.Ct. 1549, 1552, 95 L.Ed. 2d 39, 46 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137-38, 111 S.Ct. 478, 482-83, 112 L.Ed. 2d 474, 482-83 (1990); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 1676, 131 L.Ed.2d 695, 704-705 (1995) (citing previous Court rulings).

There is limited Congressional legislative history on the intent of ERISA's preemption provisions. Legislative debate was focused on the bill's funding and fiduciary requirements. The House and Senate-passed versions of ERISA only preempted state laws that covered subjects regulated by ERISA. Subcomm. on Labor of Comm. on Labor and Public Welfare, *Legislative History of ERISA*, 94th Cong., 2d Sess. 5282-84 (1977) [hereinafter *Legislative History of ERISA*]. The preemption language was broadened in conference largely due to concerns about state efforts to prevent the expansion of pre-paid legal service plans that were a perceived threat to the legal profession. Rand E. Rosenblatt, Sylvia A. Law & Sara Rosenbaum, LAW AND THE AMERICAN HEALTH CARE SYSTEM 159-177 (Foundation Press 1997). There is no evidence in the legislative history that Congress intended to preempt traditional health care regulation, medical malpractice, or similar laws.

Instead, Congress' focus was on eliminating the threat of state laws that conflicted with the substantive provisions of ERISA regulation. During House floor debate on ERISA, Representative Dent (D-PA), one of the lead House sponsors noted: "With preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent). Senator Williams echoed this explanation in the Senate. He noted that ERISA's preemption provisions are intended to ". . . eliminat[e] the threat of conflicting or inconsistent state and local regulation of employee benefit plans." 120 Cong. Rec. 29,931 (1974) (statement of Sen. Williams). In the summary of differences between the House and Senate versions of the pension reform bill, the

staff comment recommended that ". . . the conferees may want to adopt the rules of the Senate bill, but not allow suit under Title I to be brought in state court. (Suit brought in state court could be based on breach of contract, but suit could be removed, by either party, to federal court in actions involving an interpretation of this Act.)" *Legislative History of ERISA* 5276. Staff reiterated this recommended interpretation in the section on preemption. *Id.* at 5284. The legislative history demonstrates that Congress intended to create certain new federal rights exclusively subject to federal court. However, Congress expected existing contract rights to remain subject to state jurisprudence. **Tort actions were not even mentioned**.

Next, we do not see a material difference between HMOs and physicians where state laws regulating medical judgment quality are concerned. In the case of medical necessity decisions, HMO and physician conduct are identical, differing only in their point in time. They are comparable individuals and entities when making medical treatment decisions, just in different places in line. Petitioners seek to create confusion by arguing that there is no distinction between federal acts of plan administration and the medical judgments that indirectly affect plan administration. Let us show, by way of analogy, why there is, indeed, a distinction – and a critical one. When a pension plan contracts with an investment manager, the manager clearly is still subject to federal and state securities ethics law since ERISA did not preempt federal or state securities law. But, when a pension or health plan contracts with a lawyer or accountant, does ERISA preemption exempt them from state professional liability laws since ERISA section 514(b), the savings clause, does not specifically reference them? *See* 29 U.S.C. § 1144(b) (2003). In fact, during Senate debate on ERISA, Senator Javits

assured Senator Taft (R-OH) that ERISA's preemption provision was not intended to preempt state bar associations from enforcing ethical rules or disciplining members. 120 Cong. Rec. 29,949 (1974) (statement of Sen. Javits). If the Court holds that state malpractice laws do not apply to negligent acts by HMOs simply because they do business with an ERISA plan, then a wide range of other actors also must be exempt. Surely, this is not what the framers of ERISA intended.

Consistent with this interpretation, the Court in *Pegram* rejected reading a malpractice cause of action into ERISA and assumed that state malpractice law continues to govern medical judgment. Medical treatment decision-making and improper processing of benefit claims are different acts and concepts with some overlap as noted in *Pegram*. Having closed the federal door, it is inconceivable that the Court could also close the state door.

V.

THE CONGRESSIONAL DEBATE OVER THE PATIENTS' BILL OF RIGHTS AND SIMILAR LEGISLATION DEMONSTRATES CONGRESS' INTENT TO RETAIN STATE HEALTH CARE REGULATION AND PROVIDE MEANINGFUL STANDARDS AND REMEDIES FOR MEDICAL TREATMENT DECISIONS.

A. Legislative Efforts

In recent years, Congress has devoted extensive legislative activity toward remedying weaknesses in the current health insurance system by seeking to enact a "Patients' Bill of Rights," but an effective measure has yet to be signed into law. Patients' Bill of Rights legislation has included reforms addressed both to the types and form

of benefits that insurers must cover and for redress of wrongful denials of benefits. We note in particular Aetna's assertion that in recent years Congress has adhered to the principle that any damages remedy for eligibility determinations under an ERISA plan should be exclusively *federal* (Br. at 42, n. 23) (emphasis in original text). This is absolutely wrong. Let us make the record of our actions clear.

Since the failure of the 103rd Congress to pass President Clinton's proposed legislation to provide health care for all Americans, there has been considerable effort by Congress to develop minimum standards for health insurers, including appropriate remedies for wrongful injuries suffered by patients, i.e., a "Patients' Bill of Rights." [Legislation also had been introduced to overturn the Court's decision in *Pilot Life*, but was not enacted.] H.R. 1602, 102nd Cong., 1st Sess. (1991); H.R. 1881, 103rd Cong., 1st Sess. (1993). In 1995, the President established a national Advisory Commission on Consumer Rights and Quality in Health Care. The Commission reported its recommendations in 1997, and they were quickly introduced in the House by Congressman Dingell as H.R. 3605 with 193 co-sponsors and in the Senate by Senator Thomas Daschle (D-SD) as S. 1890 with 31 cosponsors. H.R. 3605, 105th Cong., 1st Sess. (1997); S. 1890, 105th Cong., 1st Sess. (1997). These bills were jointly known as the "Patients' Bill of Rights."

Concurrently, the "Patient Access to Responsible Care Act" (H.R. 1415), sponsored by Congressman Charlie Norwood (R-GA), was being considered in the House. This legislation addressed many of the same issues as the Patients' Bill of Rights and was cosponsored, bipartisanly, by 234 members of the House.

Congress was well aware of the confusion in the courts on the issue of state laws and liability under ERISA, and both H.R. 1415 (Sec. 4) and H.R. 3605/ S.1890 (Sec. 302) clarified that causes of action arising out of a health insurer's discretionary medical decision should be considered in state courts. Both bills made clear that ERISA did not preempt state causes of action. No action was taken in the 105th Congress.

During the 106th Congress both the House and Senate passed patient protection bills. The Senate's version (S.1344 sponsored by Senator Trent Lott (R-MS)) was less comprehensive and did not include a provision on the liability of health insurers. S.1344, 106th Cong., 1st Sess. (1999). The bill passed the Senate by a vote of 53-47. The House bill, H.R. 2723, introduced by Reps. Norwood and Dingell, was very similar to H.R. 1415 and H.R. 3605 from the 105th Congress. The legislation provided a detailed set of patient care standards for health insurers, including those contracting with employers, and contained remedies. On October 7, 1999, the bill passed the House by a vote of 275-151. The bill, in Section 302, provided that ERISA would *not* preempt any cause of action under state law to recover damages "resulting from personal injury or for wrongful death in connection with . . . medical services rendered by such person to or for a group health plan" or that arose "out of the arrangement by such person for the provision of . . . medical services." H.R. 2723, 106th Cong., 1st Sess. § 302 (1999). Employers were exempted from this section, except if such employer exercised "***discretionary*** authority to make a ***decision*** on a claim for benefits covered under the plan" and "the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death" *Id.* (emphasis

added). Two other amendments that were considered on the floor included alternative provisions to the remedies for patients in H.R. 2723. All but nine members of the House present and voting that day voted for a provision that would hold health insurers liable for making a medical treatment decision.

The House-Senate Conference Committee was not able to reconcile differences during the 106th Congress. However, it is important to note that in the second session of the 106th Congress, the Senate did, for the first time, pass language that held insurers liable for their discretionary decisions. The amendment by Senator Don Nickles (R-OK), S. Amdt. 3694 to H.R. 4577, passed by a vote of 51-47 on June 29, 2000.

The same scenario repeated itself in the 107th Congress. In this Congress, numerous patient protection bills were introduced, and two main bills passed, S. 1052 and H.R. 2563. S. 1052 was introduced by Senators John McCain (R-AZ), John Edwards (D-NC), and Edward Kennedy (D-MA). On June 29, 2001, S. 1052 was passed in the Senate by a vote of 59-36. Section 402 of the bill provided for the availability of civil remedies and *precluded* preemption of any state cause of action predicated upon the failure to "exercise ordinary care in making a ***decision*** regarding whether an item or service is covered under the terms and conditions of a plan or coverage" and "such failure was a proximate cause of personal injury to, or the death of, the participant or beneficiary." S. 1052, 107th Cong., 1st Sess. § 402 (2001) (emphasis added). Employers were exempted unless they participated in the decision to deny a benefit causing injury. *Id.*

H.R. 2563 was introduced by Reps. Greg Ganske (R-IA) and John D. Dingell and passed the House by a vote of 226-203 on August 2, 2001. While HR 2563 contained many of the same provisions as S. 1052, S. 1052 would have permitted state law causes of action involving medically reviewable decisions and would have expanded federal causes of action for benefit denials not based upon medical decisions. S. 1052 § 402. H.R. 2563 created a federal cause of action that could be heard in state court and subject to state law procedural rules. H.R. 2563, 107th Cong., 1st Sess. § 402 (2001). S. 1052 permitted non-economic damages to be determined by state courts under state law, and H.R. 2563 only permitted state law on damages up to a federally established cap. S. 1052 § 402, H.R. 2563 § 402. Both bills shielded employers and ERISA plans from expanded liability unless the employer or plan participated in the decision-making process. S. 1052 § 402, H.R. 2563 § 402. However, an impasse arose over whether federal limits should be imposed, not whether state law should govern accountability.

Patients' Bill of Rights legislation was again introduced in the 108th Congress: H.R. 596 and H.R. 597 by Congressman Norwood, S. 10 by Senator Daschle and S. 1945 by Senators McCain, Edwards and Kennedy. However, the lack of resolution over federal limits on state damages and the emergence of consensus on the need for Medicare coverage of prescription drugs have taken center stage over Patients' bill of rights legislation. Further, members of Congress were well aware of the Court's decision in *Pegram* and many, ourselves included, were optimistic that its findings and holding would be carried through and expanded upon by the courts.

B. Congressional Intent Cannot be Derived from a Preemption Analysis

As a critical side-note to our discussion here, we must take issue with that which is put forth in the brief for the United States. That brief claims: "'Complete preemption' reflects a Congressional intent for Section 502(a) to provide the exclusive remedies for claims that fall within the scope of that section." (U.S. Br. at 7). The government then states: "But certain statutes so completely occupy an area Congress has chosen to regulate exclusively as federal law, with a federal cause of action, '. . . that any civil complaint raising this select group of claims is necessarily federal in character,'" (citing to *Metropolitan Life v. Taylor*, 481 U.S. 58, 63-64 (1987)) (U.S. Br. at 10), that *Pilot Life* should be interpreted to reflect our rejection of remedies under state law [such as is at issue in the cases at bar] (Br. at 11), and that somehow we have clearly manifested our intent to have ERISA preempt state tort remedies for making medical decisions from which harm is claimed to have arisen. These claims do not pass muster, particularly in light of the legislative histories examined herein.

The preceding pages make clear that we never intended ERISA to preempt state-based remedies for harm resulting from those making medical decisions based upon discretionary judgment that do not meet medical standards of care. In other words, **we have never intended to preempt a state-based scheme for resolving medical negligence claims**. We recognize the sanctity of the states to regulate health care and have never clearly expressed a contrary intent by passing ERISA or other legislation. Medical decisions of the type at issue here were never even on our "radar screen" when we drafted and passed ERISA.

While our emphasis in this brief is to assist this Court with what we know best, our legislative efforts, we are compelled to reference the fact patterns in *Pilot Life* and in *Taylor* and offer an observation about analogizing them to the fact patterns in the instant cases. We note both of the cases pertained to disability benefits for back injuries. In both cases, following the injuries, disability benefits were paid, then terminated (in *Pilot Life*, benefits were also reinstated, then terminated). The lynchpin in these two cases was that *payments* were made; not that medical care was requested prospectively as being medically necessary, as in the instant two cases. To us, this prospective denial of a medical benefit is not denying payment for disability benefits (as this Court was confronted with in *Pilot Life* and *Taylor*). Thus, extrapolation of the Court's analysis of our intent in crafting ERISA using the fact patterns in those two cases would be inappropriate for the instant matters. Indeed, a difference does exist between an HMO entity providing care and treatment in this day and age of healthcare delivery and traditional insurers of days past making post-treatment coverage decisions to pay or not to pay for treatment already given. See U.S. Br. at 15. If treatment was already given and the only issue was payment, then the medical decision-making process is never implicated; only payment for care given in the past.

To put it another way, Ms. Calad needed to be hospitalized for more than one day; a decision was made to deny this request; Ms. Calad, in other words, had *not* already stayed hospitalized for more than for what her pre-certification allowed and then asked to be reimbursed for the expense of this additional time. If that were her issue, then *Pilot Life* and *Taylor* might be useful precedent. So, too, with Mr. Davila, if he had already received Vioxx but

Aetna would not pay for it following a request for payment, then payment, and solely payment, would replace any medical decision-making prospectively made as the central fact to be considered by this Court. To this extent, then, we would find the government's characterization of the Davila and Calad fact patterns to be in error. U.S. Br. at 14, 15 ("Specifically, Davila's claim requires a showing that Davila was entitled to payment for Vioxx. . . ." and, "If Calad did not have a legal right under her ERISA plan to payment. . . .").

Parenthetically, this Court in *Pilot Life* referenced our observations of the civil enforcement provisions in Sec. 502(a) of ERISA in the Conference Report (on ERISA) for causes of action arising in federal courts in similar fashion to those (suits) brought pursuant to Section 301 of the Labor-Management Relations Act of 1947 ("LMRA") (481 U.S. at 55). The Court went on to state that, when we enacted ERISA, we were aware of the preemptive force of LMRA's Section 301 for violations of contracts between an employer and a labor organization, 301's preemption of any 'state-law claim whose resolution is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract' [citation omitted], and ERISA's goal of bringing uniformity of [legal] decision which it was designed to foster. *Id.* The type of decisions based on discretionary judgment on a forward-looking basis made by petitioners in the cases at bar are neither predicated on words of a contract, analysis of terms of an agreement nor on processing a claim for care already rendered and therefore not based on a claim for inappropriately processing a claim for care given. For these reasons, and for purposes here, any linkage of words we put forth in the Conference Report on ERISA regarding

civil enforcement provisions of Section 502(a) and LMRA's Section 301 should not be persuasive in any judicial analysis.

C. Legislative Efforts Are a Beacon for the Court

The importance of the legislative action regarding the Patients' Bill of Rights is clear. On several occasions both chambers of Congress have passed patient protection legislation that would provide for state court venue and remedies for harm arising from discretionary decision-making made by entities such as before the Court here. As late as 2003 (*see* H.R. 5, § 13 at 26), there remains as well a recognition that those health insuring entities should be held liable when they make decisions as to the medical necessity of care and treatment provided beneficiaries of those entities.

There is another important aspect to what, in general, Congress has done over the last four years concerning remedies available to plan beneficiaries for their care and treatment arising out of decisions based on discretionary judgments. There should be but one venue to adjudicate harm arising from medical treatment decisions – and it should be the states and territories. To adopt a position by Aetna and Cigna in these cases would mean that, even though those entities administer health benefits and make the same decisions as healthcare providers found in doctors' offices or in hospital corridors – whether mixed eligibility and treatment or not – such entities would be subject to the federal courts to adjudicate any harm arising from their decisions, while doctors and hospitals would be subject to state courts for making precisely the same decisions. We do not countenance such duplication of legal resources, have never envisioned this through our

legislative efforts in this arena, and are certain neither would this Court. Again, as states have been charged with policing health care, i.e., regulating the medical decision-making process, so, too, states should remain the place of adjudication for claims from harm arising therefrom. Such judgments on treatment do not implicate ERISA's focus on uniform administration since these are not primarily decisions about proper processing of benefit claims, but decisions about appropriate delivery of medical care.

Furthermore, the suggestion has been advanced on behalf of petitioners that our branch of government should be the one to make more certain that which we passed with our ERISA legislation rather than for this Court to undertake it. While many occasions have existed in this Court's jurisprudence where such legislative action was necessary, the facts giving rise to the instant cases do not call for us to rethink what we did in 1974. We say this for two reasons. First, the language of our act is not a result of having consciously dealt in any way with accountability for discretionary decision-making as to medically necessary care and treatment provided participants and beneficiaries of health plans. Nor is it the result of any prior knowledge on our part of what HMOs did back in the early 1970s. *A fortiori*, we think it inappropriate for the Court to suggest that we make revisions to ERISA to language that never addressed the issues here in the first instance.

Second, our efforts to make clear what ERISA should preempt or not preempt in the area of medical decision-making was occasioned by the development of case law over the last decade, providing interpretations of ERISA, e.g. quality versus quantity of care, treatment versus administrative decisions, and even the "mixed eligibility/treatment" decision. Because the issues raised in these

cases arise from court-made interpretations of language we never enacted nor in any sense intended to enact, it appears more appropriate for this Court to take the lead in crafting a clear and distinct standard to be applied by lower courts to fact patterns such as the two put forth in these cases. It is easier for this Court to clarify its previous interpretations of preemption by ERISA, than for Congress to override employer and industry opposition and restore what we never intended to take away in the first instance.

VI.

CONGRESSIONAL REPORTS DEMONSTRATE THAT STATE LIABILITY DOES NOT SIGNIFICANTLY AFFECT EMPLOYER OR INSURER HEALTH CARE COSTS

Employers establish employee benefit plans because their employees value them and they serve the employer's economic interests, as evidenced by over $200 billion in annual tax deductions. U.S. Joint Committee on Taxation, *Estimates Of Federal Tax Expenditures For Fiscal Years 2004-2008*, Rept. JCS-8-03, 108th Cong., 1st Sess. (2003). Almost all large employers maintain a range of employee benefit plans, and small employers offer some benefits as soon as they are profitable enough to do so. Linked to this are the studies which have found that approximately 1% of the actual victims of malpractice bring a judicial action and less than 50% of plaintiffs are successful. See e.g., A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Effects Due to Negligence*, NEW ENGLAND JOURNAL OF MEDICINE, vol. 325, no. 4, July 25, 1991. Moreover, the Congressional Budget Office estimate on Patients' Bill of Rights legislation found that

the effect of its liability provisions on health care costs would be less than 1%. Congressional Budget Office Cost Estimate on S. 1052, the Bipartisan Patients' Bill of Rights Act, July 20, 2001.

Further, recent reports by both the Congressional Budget Office (CBO) and General Accounting Office (GAO) have refuted employer and insurer claims of increased costs from medical decision-making, accountability and liability. The CBO has found that malpractice costs account for less than 2% of health care spending and claims that limiting tort liability will reduce the practice of "defensive medicine" are weak or inconclusive. *Limiting Tort Liability for Medical Malpractice*, ECONOMIC AND BUDGET ISSUE BRIEF, Congressional Budget Office at 1, January 8, 2004. The CBO found that

> . . . if malpractice is defined clearly but too broadly or if awards tend to be too high, doctors may engage in defensive medicine, inefficiently restrict their practices, or retire. Conversely, if doctors face less than the full costs of their negligence – because they are insulated by liability insurance or because malpractice is unrecognized or under-compensated – they may have too little incentive to avoid risky practices. For all of those reasons, it is not clear whether trying to control malpractice by means of liability improves economic efficiency or reduces it.

Id. at 2. Similarly, the GAO released two reports examining issues related to medical malpractice and health care costs and found that claims that liability costs affect access to health care were "limited" and "cannot be generalized". *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, US General Accounting Office at 1, GAO-03-836, August 2003; *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, US General Accounting Office, GAO-03-702, June 27, 2003.

Consequently, the fears of employers and their intermediaries that state liability will chill employee benefit plans and ERISA's scheme of uniformity are simply unfounded. There are many ways in which ERISA plans and providers adhere to state standards, including state statutes of limitations, mandated benefit requirements for insurance, and enforcement of judgments. As always, employers and service providers will successfully adjust. In contrast, without some state protections, hundreds of millions of workers, retirees, and their families would have no source of protection. At a time when access to health care is more valuable than ever and federal solutions more elusive than ever, the states are critical protectors of our fraying health care system.

CONCLUSION

Justice O'Connor was exactly right when she wrote for the Court in *Pilot Life*: "The question whether a certain state action is pre-empted by federal law is one of congressional intent. '***The purpose of Congress is the ultimate touchstone.***'" 481 U.S. at 45 (citations omitted) (emphasis added). As *Amici Curiae,* we hope this brief has shed light on that touchstone: we never intended ERISA to preempt state-based tort remedies grounded in malpractice jurisprudence brought against managed care entities, i.e., HMOs, based on their personnel denying on a prospective basis a request for care and treatment as not medically

necessary where the denial results from medical decision-making based upon the exercise of discretionary judgment.

For the foregoing reasons, we respectfully request that the decisions of the Fifth Circuit be affirmed.

Respectfully submitted,

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v.
JUAN DAVILA, *Respondent*.

CIGNA HEALTHCARE OF TEXAS, INC., *Petitioner*
v.
RUBY R. CALAD, ET AL., *Respondents*.

On Writs Of Certiorari to the United States Court of Appeals for the Fifth Circuit

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AMICUS CURIAE BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA IN SUPPORT OF RESPONDENTS

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Nos. 02-1845 and 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH INC., *Petitioner*,
v.
JUAN DAVILA, *Respondent*.

CIGNA HEALTHCARE OF TEXAS, INC., *Petitioner*
v.
RUBY R. CALAD, ET AL., *Respondents*.

On Writs Of Certiorari to the United States Court of Appeals for the Fifth Circuit

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AMICUS CURIAE BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA IN SUPPORT OF RESPONDENTS

IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Association of Trial Lawyers of America ["ATLA"] respectfully submits this brief as *amicus curiae*. The parties have filed letters of consent to the filing of amicus briefs with this Court.[1]

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[1] Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did any person or entity other than Amicus Curiae, its members, or its counsel

ATLA is a voluntary national bar association whose approximately 50,000 trial lawyer members primarily represent individual plaintiffs in civil actions.

Many of those individuals are those who have suffered harm due to substandard medical care. Increasingly, as managed care has come to dominate the health care delivery system, they include those harmed by poor medical decisions, not by their treating physicians, but by plan administrators or others performing utilization review in the managed care setting.

In ATLA's view, the Texas Health Care Liability Act, which holds insurers, HMOs, and managed care entities accountable when they fail to use ordinary care when making medical decisions, provides an incentive to minimize such harm and affords access to a legal remedy for wrongfully injured victims.

SUMMARY OF THE ARGUMENT

1. This case, like every preemption case, is about federalism. Respondents' causes of action arise under the Texas Health Care Liability Act, which requires health insurers, HMOs and managed care entities to use due care when they make health treatment decisions, including determinations of "medical necessity" under an ERISA plan. Petitioners contend that these damage actions are preempted – not under the express preemption provisions Congress included in ERISA, but by operation of implied

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make a monetary contribution to the preparation or submission of this brief.

"complete preemption" of ERISA's civil enforcement provisions.

ATLA urges this Court to define the scope of this implied preemption narrowly. This Court has consistently emphasized that to protect the role of the sovereign states, it will find preemption of state law only where Congress has made clear and manifest its intent to do so, particularly strong where, as here, Congress has acted in an area traditionally regulated by the states. Moreover, the presumption applies not only to the question of whether federal law supersedes state law, but also to the scope of preemption.

By requiring that Congress make its intent clear and manifest, the Court preserves the structural protection of the states through their representation in Congress. At the same time, the Court allows states to serve as laboratories in protecting the health and welfare of their citizens and preserves the political accountability of local officials in the exercise of this responsibility. Broad application of implied preemption by the judiciary undermines federalism.

Narrowly circumscribing preemption in this case is also necessary to avoid depriving wrongfully injured persons of any legal remedy. The right of access to the courts for legal redress is a fundamental right, grounded in the Constitution and in the foundations of the common law. This Court has suggested that legislation which deprives wrongfully injured persons of all means of remedy violates due process. At the least, this Court should not impute to Congress the unexpressed intention to shut the courthouse doors to the very persons ERISA was intended to protect.

2. The court of appeals below correctly restricted the scope of preemption state causes of action that duplicate the duties established in ERISA itself. The structure of the statute, which imposes duties that are administrative and procedural in nature, indicates that Congress did not intend to eliminate state law duties concerning the quality of medical treatment decisions.

This Court has laid out a clear path for determining whether a plaintiff's cause of action is preempted by federal requirements. That analysis looks to the duties that are the predicate for plaintiff's cause of action. In this case, the duty of care imposed by the Texas act does not duplicate or conflict with the administrative and procedural duties imposed by ERISA. Indeed, as this Court has indicated, Congress appears to have assumed that state professional liability standards would continue to serve as a check on the financial interests of providers. ERISA's savings clause, preserving state laws that, like the Texas statute, regulate insurance, strongly indicates the intent of Congress to save such state regulation from preemption.

3. Petitioners' alarmist warnings that upholding the Texas statute will result in substantial increases in the cost of benefit plans are contrary to the experience in Texas and elsewhere. Liability of managed care entities has resulted in neither a flood of litigation nor significant increases in premiums. More fundamentally, balancing the costs of liability against the reduction of wrongful injury is one that is most appropriate for the legislature. The Texas legislature has done precisely that, and this Court should not set aside the result.

ARGUMENT

I. THE SCOPE OF STATE LAW PREEMPTED BY ERISA'S CIVIL ENFORCEMENT PROVISIONS MUST BE NARROWLY DRAWN.

A. Preemption of State Causes of Action, Beyond Those Which Duplicate the Federal Causes of Action Provided by ERISA, Intrudes Upon Traditional State Responsibility for Protecting Health and Safety.

Every preemption case is about federalism. The Supremacy Clause grants Congress the power to set aside the laws of the States. U.S. Const., art. VI, cl. 2. In determining whether Congress has exercised this substantial power, the intent of Congress provides the "ultimate touchstone." *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 45 (1987) (quoting prior cases), and the judiciary's "sole task is to ascertain the intent of Congress." *California Federal Savings and Loan Ass'n v. Guerra,* 479 U.S. 272, 281 (1987).

In many cases and in many circumstances, especially in matters involving the health and safety of Americans, this Court has approached this task with a "strong presumption against preemption." *Cipollone v. Liggett Group, Inc.,* 505 U.S. 504, 523 (1992). The Court has stated it will find preemption only where Congress has made its intent to override state law "clear and manifest." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), quoted in *Cipollone*, *supra*, at 516; and in *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996).

Requiring that Congress make clear its intent to override state law "provides assurance that the

federal-state balance . . . will not be disturbed unintentionally by Congress or unnecessarily by the courts." *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). The Court thereby promotes a healthy federalism by "avoiding unintended encroachments on the authority of the States." *CSX Transp. Inc. v. Easterwood,* 507 U.S. 558, 664 (1993).

This presumption against preemption applies not only to the question of whether Congress intended to preempt state law, but it also requires that courts narrowly define the scope of preemption. *Medtronic, Inc. v. Lohr, supra,* at 485; *Cipollone, supra,* at 518. *See also CSX Transp. Inc. v. Easterwood, supra*, at 658-59 (narrowly construing the scope of express preemption under the Federal Railroad Safety Act "in light of the presumption against preemption").

This principle is fully applicable to questions regarding the scope of preemption of state law by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq*. Addressing ERISA's express preemption provision, § 514(a), 29 U.S.C. § 1144(a), the Court stated:

> [I]n cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

New York State Conference of Blue Cross & Blue Shield Plans, Inc. v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (citations omitted).

Narrowly construing the scope of federal preemption is necessary to preserve "the

constitutional role of the States as sovereign entities." *Alden v. Maine*, 527 U. S. 706, 713 (1999). The Court in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), determined that the States do not enjoy substantive protection under the Tenth Amendment. Rather, their sovereign interests "are more properly protected by the procedural safeguards inherent in the structure of the federal system," by virtue of the States' representation in Congress. *Id.* at 552.

The corollary to this proposition is that the States must be assured meaningful opportunity to protect their interests by requiring that Congress make clear the extent to which federal legislation is to override state law. As Justice O'Connor has explained:

> By declining to infer preemption in the face of congressional ambiguity, the Court is . . . furthering the spirit of *Garcia* by requiring that decisions restricting state sovereignty be made in a deliberate manner by Congress, through the explicit exercise of its lawmaking power to that end.
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> * * *
>
> Application of the plain statement rule thus may avoid a potential constitutional problem. Indeed, inasmuch as this Court in Garcia has left primarily to the political process the protection of the States against intrusive exercises of Congress' Commerce Clause powers, we must be absolutely certain that Congress intended such an exercise.

Gregory v. Ashcroft, 501 U.S. 452, 464 (1991). *See also Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861, 907 (2000) (Stevens, J., dissenting).

Petitioners in this case ask the Court to broadly extend the scope of "complete" preemption under § 502(a) of ERISA, 29 U.S.C. § 1132(a). Significantly, the Court's decision that a claim for benefits that falls within § 502(a) is completely preempted, not only invalidating the state law claim but transforming it into one that arises under federal law, is not based on the text of the statute. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987).

ATLA submits that the range of state laws subject to this "extraordinary preemptive power," *id.* at 65, be narrowly circumscribed.

The "regulation of health and safety matters is primarily and historically, a matter of local concern." *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719 (1985). The licensing, regulation, and tort liability of physicians, hospitals and other health care providers is the responsibility of the states. Regulation of the business of insurance is the exclusive province of the states. McCarran-Ferguson Act, 15 U.S.C. § 1012(b).

Yet Petitioners would deprive state lawmakers of the authority to protect their citizens in the changing medical care system, locking them into a regime of non-accountability for medical care organizations despite the lack of any clear evidence of congressional intent to do so. Such unduly broad preemption forecloses one of the "happy incidents of our federal system," that a state may serve as a "laboratory" in protecting the health and wellbeing of its citizens as health care delivery changes. *New State Ice Co. v. Liebman*, 285 U.S. 262, 280 (1931) (Brandeis, J., dissenting).

Equally important, the proper federal-state balance preserves the political accountability of officials responsible for taking such actions. "Federalism serves to assign political responsibility, not to obscure it." *United States v. Lopez*, 514 U.S. 549, 577 (1995), quoting *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992). Narrowly construing the unexpressed intent of Congress to override state law preserves the objective that "state governments remain responsive to the local electorate's preferences [and] state officials remain accountable to the people." *New York v. United States*, 505 U.S. 144, 168 (1992).

Focusing on the institutional responsibility of the judicial branch, Judge Kenneth Starr has pointed out the dangers of the course urged by Petitioners:

> When courts preempt state laws without explicit congressional guidance, unelected and unaccountable officials substitute their preferences for those of the citizens of local communities. Unguided preemption thus erodes our national commitment to the process of self-governance . . . When judges preempt state laws in the absence of explicit congressional guidance, they in effect assume a legislative role without accepting legislative responsibility. [In addition] the overarching guarantee of "Our Federalism" is defeated.

Kenneth Starr, et al., THE LAW OF PREEMPTION: A REPORT OF THE APPELLATE JUDGES CONFERENCE OF THE AMERICAN BAR ASSOCIATION 48-49 (1991).[2]

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[2] *See also Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861, 907 (2000) (Stevens, J., dissenting) ("the presumption

B. This Court Should Narrowly Define the Preemptive Scope of ERISA's Civil Enforcement Provisions To Avoid Depriving Wrongfully Injured Persons of All Legal Remedies.

1. The Right of Access To the Courts To Seek Legal Redress For Injury Is a Fundamental Right.

From our nation's earliest days, this Court has recognized the duty of government to provide legal recourse for injury. Chief Justice Marshall stated:

> [T]he very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury. One of the first duties of government is to afford that protection.

Marbury v. Madison, 5 U.S. (1 Cranch) 137, 163 (1803). As Justice O'Connor has observed, "[T]he federal interest in ensuring that all citizens have access to the courts is obviously a weighty one." *Three Affiliated Tribes of the Fort Berthold Reservation v. Wold Engineering*, 476 U.S. 877, 887 (1986) (citations omitted). More recently, this Court confirmed that this right is fundamental and grounded in the Constitution. *Christopher v. Harbury*, 536 US. 403, 414 n.12 (2002).

The ancient right of access to the courts to seek legal remedy for wrongful injury predates the

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serves as a limiting principle that prevents federal judges from running amok with our potentially boundless (and perhaps inadequately considered) doctrine of implied conflict pre-emption based on frustration of purposes").

Constitution itself. Lord Coke traced it to the Magna Carta,[3] and Blackstone declared it to be an "invariable principle in the laws of England, that every right, when withheld, must have a remedy, and every injury its proper redress."[4] This Court has pronounced it "the duty of every State to provide, in the administration of justice, for the redress of private wrongs" under the Due Process Clause of the Fourteenth Amendment. *Missouri Pacific Ry. Co. v. Humes*, 115 U.S. 512, 521 (1885).

The right to a remedy is expressly guaranteed in the state constitution of Texas,[5] and in 38 other state constitutions. David Schuman, *The Right to a Remedy*, 65 Temple L. Rev. 1197, 1199-1201 (1992).

The common law cause of action for injuries and deaths caused by medical malpractice is well settled in every state. Andrew A. Sandor, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459 (1957) (citing the first malpractice decision in each state). Following

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3 Every Subject may take his remedy by the course of the Law, and have justice, and right for the injury done to him, freely without sale, fully without denial, and speedily without delay.

Edward Coke, SECOND PART OF THE INSTITUTES OF THE LAWS OF ENGLAND 55-56 (4th ed. 1671).

4 3 William Blackstone, COMMENTARIES ON THE LAWS OF ENGLAND *23 & *109 (1765).

5 All courts shall be open, and every person for an injury done him, in his lands, goods, person or reputation, shall have remedy by due course of law.

Vernon's Ann. Texas Const. Art. I, sec.13.

hearings and testimony concerning harms cause by negligent medical decisions by managed care organizations, the citizens of Texas, through their elected representatives, extended the malpractice cause of action to "health insurance carrier, health maintenance organization, or other managed care entity for a health care plan." Tex. Civ. Prac. & Rem. Code Ann. § 80.002(a). *See* Comment,. Scott Thornton, *The Texas Health Care Liability Act: Managed Care Organizations Can Say Goodbye To Their Extensive Immunity From Lawsuits – Or At Least That Was How It Was Supposed To Work,* 30 Tex. Tech L. Rev. 1227, 1233-35 (1999). The legislation was enacted with overwhelming bipartisan support. *Id.* Essentially, the Texas Act does not require insurers or HMOs to provide any particular benefit. However, if they insist on making medical judgments, they must exercise care in doing so and may be held accountable for the harm they cause by breaching that duty. *See* Note, Shannon Turner, *ERISA Preemption of Direct Liability claims: Texas Throws Down the Gauntlet,* 78 Tex. L. Rev. 211, 214 (1999).[6]

It is undisputed that ERISA imposes no duty with respect to the quality of medical treatment decisions, nor does it provide any cause of action for compensatory damages arising from the failure to exercise due care. The broad preemption sought by Petitioners would close the doors of the courthouse to

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[6] Legislative action was necessary to overturn *Williams v. Good Health Plus, Inc.-HealthAmerica Corp.*, 743 S.W.2d 373, 378 (Tex. Ct. App. 1987) (holding that, because corporations cannot practice medicine, HMOs cannot be liable for medical malpractice). *See* Turner, *supra*, at 213-14.

victims of such failure to use due care, leaving them without any legal remedy.

This Court has indicated that complete elimination of state tort actions for compensation of injury may violate substantive due process unless the legislature has provided a reasonable alternative remedy. For example, this Court has upheld the elimination of tort actions by workers for job-related injuries where the legislature has provided "a reasonably just substitute" in the form of workers' compensation. *New York Central R. Co. v. White*, 243 U.S. 188, 198 (1917). Similarly, the Court held that the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C.A. § 901 et. seq. did not violate due process where Congress provided a federal statutory benefit scheme in place of maritime tort causes of action for injury. *Crowell v. Benson*, 285 U.S. 22, 40-44 (1932) (citing authorities addressing both state and federal legislation). *See also United Construction Workers v. Laburnum Const. Co.*, 347 U.S. 656, 665 (1954).

This Court in *Duke Power Co. v. Carolina Environmental Study Group,* 438 U.S. 59 (1978), suggested that the complete abolition in the Price-Anderson Act of common-law tort suits for damages in nuclear power accidents might violate substantive due process except for the "panoply of remedies and guarantees" provided by Congress. *Id.* at 86-88 and 91-93. As Justice Marshall later remarked, "our cases demonstrate that there are limits on governmental authority to abolish 'core' common-law rights, . . . at least without a compelling showing of necessity or a provision for a reasonable alternative

remedy." *PruneYard Shopping Center v. Robins,* 447 U.S. 74, 93-94 (1980) (Marshall, J., concurring).[7]

This Court need not delimit here the outer boundaries of Congress' authority in this regard.

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[7] In *Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861 (2000), *Norfolk Southern Ry. Co. v. Shanklin*, 529 U.S. 344 (2000) and in *Cipollone, supra*, this Court held that federal regulations preempted certain state tort causes of action. Those cases, however, are distinguished by the direct conflict between the state law and federal regulation.

In *Shanklin* and *Cipollone*, this Court viewed state tort actions as equivalent to state regulation that was inconsistent with and preempted by express preemption provisions enacted by Congress. *See Cipollone* at 521, quoting *San Diego Building Trades Council v. Garmon,* 359 U.S. 236, 247 (1959)(state "regulation can be as effectively asserted through an award of damages as through" administrative regulation). In this case there is no such conflict because the Texas law is limited to treatment decisions and ERISA § 202 does not address the quality of treatment decisions.

Significantly, the *Garmon* Court carefully conditioned its ouster of state law on the understanding that access to justice would be assured through alternative federal remedies. The majority opinion emphasized the fact that the NLRA established a set of procedures and remedies in place of the state law remedies displaced by the Act. 359 U.S. at 243. Justice Harlan, in his concurring opinion, cautioned that, where Congress has not provided a remedy for tortious conduct, "there is no ground for concluding that existing criminal penalties or liabilities for tortious conduct have been eliminated." *Id.* at 252 (Harlan, J., concurring).

Geier, by contrast, involved implied "conflict" preemption of state law. This Court carefully distinguished such preemption from congressional "intent to displace *all* state law in a particular area." *Id.* at 884. ATLA suggests that the latter variety of preemption, which the Court referred to as "so-called field pre-emption," is the type which § 502 of ERISA presents to this Court.

Congress has given no clear and manifest indication in ERISA of any intent to eliminate state causes of action for harm caused by negligent treatment decisions, and Petitioners point to none. In ascertaining the extent of Congress' intent to supersede state law, this Court has repeatedly stated that it will not read into congressional silence an intent to leave injured persons without any remedy at all.

For example, *Pacific Gas & Elec. Co. v. Energy Resources Comm'n.*, 461 U.S. 190, 212 (1983), held that Congress intended to occupy the field of safety regulation of nuclear power facilities. Nevertheless, this Court held the following year that the preempted field did not extend to state tort actions for injury caused by negligent administration of safety regulations. In *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238 (1984), the Court pointedly noted "Congress' failure to provide any federal remedy for persons injured by such conduct." Justice White, writing for the majority, concluded that Congress could not have intended to preempt state tort causes of action. "It is difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct." 464 U.S at 251. Justice Blackmun, in his dissent, agreed with the majority on this point. "The absence of federal regulation governing the compensation of victims is strong evidence that Congress intended the matter to be left to the States." 464 U.S. at 264 n.7. (Blackmun, J., dissenting).

The Court subsequently held that, even if liability under state workers' compensation statutes or state tort remedies might exert an indirect influence over how nuclear plants carry out federal

safety regulations, Congress did not intend to preempt such state causes of action and leave injured persons without remedy. *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 185 (1988), and *English v. General Electric Co.*, 496 U.S. 72, 85 (1990). *Compare, International Paper Co. v. Ouellette,* 479 U.S. 481, 497 (1987) (finding implied preemption of state nuisance law by the federal Clean Water Act, where the result "does not leave respondents without a remedy.").

The Court took much the same position in *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Rejecting the company's assertion that the scope of Congress' express preemption of state standards in the federal Medical Device Amendments extended to state causes of action for personal injury, Justice Stevens wrote for the plurality:

> Medtronic's argument is not only unpersuasive, it is implausible. Under Medtronic's view of the statute, Congress effectively precluded state courts from affording state consumers any protection from injuries resulting from a defective medical device. Moreover, because there is no explicit private cause of action against manufacturers contained in the MDA, and no suggestion that the Act created an implied private right of action, Congress would have barred most, if not all, relief for persons injured by defective medical devices. Medtronic's construction of § 360k would therefore have the perverse effect of granting complete immunity from design defect liability to an entire industry that, in the judgment of Congress, needed more stringent regulation.

518 U.S. at 487 (plurality opinion).

ATLA submits that these same principles should lead this Court to reject Petitioners' argument that Congress impliedly intended the scope of preemption under § 502(a) of ERISA to include state law causes of action like that provided under the Texas statute. Petitioners would have this Court slam shut the courthouse doors that the people of Texas, through their elected legislators, have held open.

Such a result would be an especially unlikely and perverse outcome of Congress' work in ERISA. The statute's stated purpose was to protect the rights of American workers and their families, a valued constituency of all legislators. This Court should hesitate to impute to Congress the intent to enact a law that is not only unjust, but senselessly so.

II. ERISA'S CIVIL ENFORCEMENT RULES PREEMPT ONLY THOSE STATE LAW CAUSES OF ACTION WHICH DUPLICATE THE ENFORCEMENT OF ADMINISTRATIVE AND PROCEDURAL DUTIES CREATED BY ERISA.

A. ERISA's Civil Enforcement Provisions Reflect Congressional Intent To Federalize Only Those Administrative Duties Created By ERISA.

Congress' intent may be "explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Cipollone* at 516, quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). In cases involving ERISA preemption, the Court has looked to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *New York State*

Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 656 (1995).

Congress enacted ERISA in 1974 "to promote the interest of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). *See* 29 U.S.C. § 1001(a) (1994). Congress did not mandate any particular set of benefits, nor did it regulate the quality of treatment decisions. "ERISA thus contains almost no federal regulation of the terms of benefit plans." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). Rather, ERISA "controls the administration of benefit plans." *Travelers*, *supra,* at 651.

ERISA establishes uniform duties for plan administrators and individual rights for plan participants regarding the way the plan is administered, notice and appeal procedures. *See* Rand E. Rosenblatt et al., LAW AND THE AMERICAN HEALTHCARE SYSTEM 197 (1997 & Supp.) (discussing mandated benefits under ERISA).

In § 502 Congress established the means to enforce the rights and duties prescribed in the statute. It was clear to this Court that these duties are administrative and procedural in nature.

> Under the civil enforcement provisions of § 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits.

Pilot Life, supra, at 53. "In sum," the Court stated, "the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme" to address "the need for prompt and fair claims settlement procedures." *Id.* at 54. In addition, Congress "makes clear its intention that all suits brought by beneficiaries or participants *asserting improper processing of claims* under ERISA-regulated plans be treated as federal questions governed by § 502(a)." *Id.* at 56 (emphasis added).

In *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000), this Court held that the civil enforcement provisions in § 502 were intended to enforce federal duties on plan administrators regarding "pure eligibility" decisions, which the Court defined as decisions which "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* at 228. The statute imposes no duties with respect to treatment decisions "about how to go about diagnosing and treating a patient's condition." *Id.* Nor does the statute impose any duties with respect to "mixed eligibility decisions," including a determination of medical necessity. *Id.* at 229-30. Indeed, the Court observed, "it is at least questionable whether Congress would have had mixed eligibility decisions in mind" when it provided for enforcement of the fiduciary duties of those administering a plan. *Id.* at 232.

The structure of the statute, which imposes only administrative duties focusing on pure eligibility decisions, and the statute's purpose of providing enforcement of uniform prompt and fair claims procedures, suggest that Congress intended complete preemption only of a state cause of action that has "duplicated the elements of a claim

available under ERISA." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

The court of appeals, ATLA submits, correctly defined the scope of preemption under § 502 of ERISA.

B. The Scope of Preemption of State Causes of Action Under Section 502 Is Defined By the Duties Imposed By ERISA.

1. Petitioners' Description of the Scope of Preemption Under § 502 Is Overly Broad and Unworkable.

Petitioners reject the reasoning of the court below, which limited the scope of preemption under § 502 to state causes of action that duplicate the elements of a claim under ERISA. They urge this Court to extend the scope of preemption far beyond those elements to include claims involving treatment decisions that Congress did not provide for. However, Petitioners offer no clear, workable boundaries to determine what is preempted, and they depart from the path that this Court has clearly marked.

Aetna suggests that the scope of preemption be based on the type of damages plaintiff seeks. Aetna argues, "any state-law remedy that offers plan participants a form of relief not available under ERISA is completely preempted." Brief of Aetna Health Inc. at 12. In Aetna's view, "Section 502(a)(1)(B) does not permit the award of legal relief — such as consequential and punitive damages other than withheld benefits." *Id.* at 20.

ATLA submits that Aetna confuses "remedies" with damages. Suppose an HMO administered an ERISA plan in a racially discriminatory manner, or in a manner that violated state patient privacy laws.

Aetna's position suggests that the HMO should be immune from such claims if they seek compensatory or punitive damages. If an HMO is not to be completely immune from damage claims for even egregious misconduct, Aetna offers no boundary to divide permissible claims for legal damages from preempted claims.

Later in its brief, Aetna appears to refine its argument, stating that "an action is within the scope of ERISA's remedial provision — and is therefore completely preempted – if it challenges conduct that could have been challenged in an ERISA action, but . . . purports to authorize actions for relief not permitted by ERISA or based on conduct not actionable under ERISA. *Id.* At 26.

ATLA suggests that this self-negating definition of preempted causes of action – those based on conduct which could be challenged in an ERISA action, but not actionable under ERISA – is less than helpful.

Cigna adopts a somewhat different approach, asserting that the scope of preemption extends to state law causes of action seeking damages for wrongful denial of benefits. "The sole monetary remedy a court may provide in such an action is the benefit itself; [the civil enforcement provisions] thus preempt any state-law claims that purport to provide different or additional remedies for allegedly erroneous benefit denials" Brief of Cigna HealthCare of Texas at 5. Hence, Cigna reasons, "a state-law contract or tort claim asserting that a benefit under an ERISA-governed plan was improperly denied, and seeking remedies different from or in addition to the exclusive set of remedies set forth in ERISA § 502(a), is preempted." *Id.* at 17.

The Solicitor General echoes this view that the scope of preemption is defined by the plan's conduct in denying benefits. "Respondents' state-law claims are completely preempted . . . because petitioners' liability is dependent on a showing that respondents were entitled to have petitioners pay for benefits under the plans." Brief of the Unites States as Amicus Curiae at 7.

The error inherent in the views of Cigna and the Solicitor General is that Congress does not preempt conduct; it preempts state law – in this case a state-law cause of action. The gist of Petitioners' cause of action is failure to exercise ordinary care in making treatment decisions. Whether the patient was entitled under the plan to the medicine or procedure involved may be a circumstance, but it is not an element of the state law claim.

Plaintiff Davila, for example, suffered injury caused not by denial of Vioxx, but by the administration of naprosyn, despite its known higher rate of gastric toxicity, resulting in severe gastric ulcers. *Roark v. Humana, Inc.*, 307 F.3d 298, 303 (5th Cir. 2002). Walter Thorn, whose case was also decided by the court below, asserted a cause of action based on his plan's arbitrary delay in performing a surgery that had already been approved. *Id.* at 302.

ATLA submits that the reasoning of the court of appeals adheres most faithfully to this Court's preemption precedents.

> *2. The Scope of Preemption Under § 502 Is Determined by Examining the Legal Duty Which Forms the Basis For A Plaintiff's Cause of Action.*

Petitioners' arguments stray far from the well-marked path this Court has laid out for determining whether a state cause of action is preempted by congressionally mandated requirements:

> [W]e must fairly but – in light of the strong presumption against pre-emption – narrowly construe the precise language of [the express preemption] and we must look to each of petitioner's common-law claims to determine whether it is in fact pre-empted. The central inquiry in each case is straightforward: *we ask whether the legal duty that is the predicate of the common-law damages action* constitutes [a preempted "requirement or prohibition"].

Cipollone, at 523-24. (emphasis added). *Compare Medtronic*, *supra*, at 492-502, in which the Court examined the predicate legal duty of each of plaintiff's state causes of action to determine whether it fell within the preempted zone.

The Texas Health Care Liability Act provides:

> A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

Tex. Civ. Prac. & Rem. Code § 88.002(a). A "health care treatment decision" is "a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Tex. Civ. Prac. & Rem. Code § 88.001(5). The statute specifically provides that there is "no obligation on the part of the health insurance carrier, health

maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity." Tex. Civ. Prac. & Rem. Code § 88.002(d).

By its terms, the statute imposes no duty with respect to the administration of plans, which is the subject of ERISA. Pure eligibility decisions, for example, are not actionable under the statute. Rather, the "legal duty that is the predicate" of a cause of action under the THCLA is the duty to exercise ordinary care with respect to treatment decisions, a duty that ERISA does not encompass.

C. Congress Intended To Preserve Medical Malpractice Liability Under State Law.

Federal law has a "generally interstitial character, in the sense that Congress generally enacts legislation against the background of existing state law." *Three Affiliated Tribes of the Fort Berthold Reservation v. Wold Engineering*, 476 U.S. 877, 895-96 (Rehnquist, J., dissenting) (citations omitted).

The is particularly true with respect to ERISA. The Court found that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, *supra*, at 661.

Indeed, this Court determined that the state medical malpractice standard, "the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest," would serve as a "check" on HMO doctors so that treatment decisions are not made

solely on the basis of financial interest. *Pegram*, *supra*, at 219.

The HMO itself, of course, has the same financial interest in providing less or cheaper care. As this Court also observed, "many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines." *Id.* at 220. The Texas legislators made use of the same "check" to counter this financial pressure by requiring that HMOs and managed care entities use ordinary care when making treatment decisions.

Significantly, the Court in *Pegram* indicates that Congress envisioned statutes like the THCLA to operate as part of the "general background" of state law. The Court stated that allowing a federal suit against an HMO under § 502 for the medical necessity decision of a physician-owner would be "mere replication of state malpractice actions with HMO defendants." *Id.* at 236. The only jurisdictions in which such a federal cause of action would be beneficial, the court stated, were those "States that do not allow malpractice actions against HMOs." *Id.* at 235.

The Court raised the idea that such potential duplication "would seem to be a prescription for preemption of state malpractice law." *Id.* Just a quickly, however, the Court stated that the presumption against preemption "throws some cold water on the preemption theory." *Id.* at 237. In the absence of any indication that Congress intended to federalize the law of medical malpractice, the Court concluded that plaintiffs should look to state law, including "state malpractice actions with HMO defendants" for relief.

D. ERISA's Express Preemption and Savings Clauses Indicate the Intent of Congress to Preserve State Laws Regulating the Quality of Treatment Decisions by Insurers, HMOs, and Managed Care Entities.

Further evidence of Congress' intent to leave intact state laws like THCLA, which impose a duty of care on HMOs and managed care entities when they make health treatment decisions, is found in ERISA's express preemption provision.

Congress expressly preempted all state laws that "relate to any employee benefit plan." Sec. 514(a), as set forth in 29 U.S.C. § 1144(a). However, Congress added a savings clause, stating that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." Sec. 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A).

The Texas statute is clearly one that regulates insurance. THCLA's duty of "ordinary care" applies to a "health insurance carrier, health maintenance organization, or other managed care entity for a health care plan." Tex. Civ. Prac. & Rem. Code § 88.002(a).

In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), for example, this Court considered an Illinois statute allowing insureds under health insurance plans to have denials of certain health benefits reviewed by an independent medical reviewer. This Court found that the Illinois Act "related to" ERISA under §514(a). *Id.* at 365. However, the statute "regulated insurance" under

§514(b)(2)(A), and was therefore saved from preemption. *Id.* at 375.

THCLA, like the Illinois statute, imposes an external standard on "medical necessity" decisions by health care plans. Illinois implemented its standard through an independent medical review; Texas requires health insurance carriers, HMOs, and other managed care entities to meet a standard of "ordinary care." Like the Illinois enactment in *Rush Prudential*, the THCLA is saved from preemption by the savings clause.

At the least, Congress' explicit delineation of the scope of preemption within the statutory text "necessarily contains the best evidence of Congress' pre-emptive intent." *Easterwood*, *supra*, 507 U. S. at 664. As this Court has explained:

> When Congress has considered the issue of pre-emption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a "reliable indicium of congressional intent with respect to state authority," *Malone v. White Motor Corp.*, 435 U.S., at 505, 98 S.Ct., at 1190, "there is no need to infer congressional intent to pre-empt state laws from the substantive provisions" of the legislation. California Federal Savings & Loan Assn. v. Guerra, 479 U.S. 272, 282, 107 S.Ct. 683, 690, 93 L.Ed.2d 613 (1987) (opinion of Marshall, J.). *Congress' enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted.*

Cipollone v. Liggett Group, Inc., 505 U.S. 504, 517 (1992) (emphasis added).

III. HOLDING HMOS ACCOUNTABLE FOR THE HARMS THEY CAUSE BY FAILING TO EXERCISE DUE CARE WILL NOT RESULT IN INORDINATE LITIGATION OR HIGHER INSURANCE COSTS.

Petitioners issue dire warnings to this Court against allowing states to hold HMOs accountable for the harm they cause. They claim that the result "will vastly increase the costs of providing benefits," Brief of Cigna Healthcare at 48, and that "affirmance of the decision below would deal a severe blow to the American economy." Brief of Aetna Health Inc. at 44.

Neither petitioner offers any evidence to support these alarmist predictions. Indeed, the amicus brief filed by the AAHP-HIAA states that "there is no reason to think that there is a widespread problem of plan participants wrongly denied coverage for necessary care, and then subjected to bad medical outcomes." Brief of AAHP-HIAA et al. at 22.

That assessment is confirmed by a study of over 1 million public employees, who are not barred by ERISA preemption from bringing such lawsuits. The study estimated that liability added only 3 to 13 cents per month to a member's cost for coverage. Kaiser Family Foundation, "Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS, Other Large Public Employers, and a Large California Health Plan" (June 1998) available at www.kff.org/statepolicy/1415-erisa.cfm.

A study of Texas and five other states that permit lawsuits against managed care entities found that litigation and the impact on insurance

premiums have been minimal. Mark A. Hall and Gail Agrawal, "The Impact of State Managed Care Liability Statutes," 22 Health Affairs 138 (2003). *See also* Geri Aston, "Texas Trial: HMO Liability Law," American Medical News (May 28, 2001) (reporting 15 to 25 lawsuits had been filed under the THCLA since its enactment and that HMO premiums in Texas remained below the national average).

Against any costs, of course, must be weighed the value of injuries and deaths averted by imposing a financial incentive for HMOs and other managed care entities to use due care when making treatment decision.

More fundamentally, as Justice Souter observed, the "judgment about the appropriate level of expenditure for health care in light of the associated malpractice risk" is properly left to the legislature. *Pegram v. Herdrich*, 530 U.S. 211, 221 (2000).

Writing for a unanimous Court, Justice Souter continued:

> [S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health-care expenditure.

Id. The Texas legislature employed just such a process in crafting the THCLA, and its members are accountable to the people of Texas. This Court should not cast aside the result of their work.

CONCLUSION

For the above reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

AETNA HEALTH INC.,
Petitioner,

v.

JUAN DAVILA,
Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,
Petitioner,

v.

RUBY R. CALAD, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS AS AMICUS CURIAE SUPPORTING RESPONDENTS

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INTEREST OF AMICUS CURIAE

The National Alliance for Model State Drug Laws (hereinafter "National Alliance") is an organization that exists as a resource for governors, state legislators, district attorneys, attorneys general, drug and alcohol abuse prevention and addiction treatment professionals, the recovering community, and others striving for comprehensive and effective drug and alcohol control laws and policies. The National Alliance receives funding from the United States Congress, *see* H.R.J. Res. 2, 108th Cong. (2003), and is the institutional successor to the President's Commission on Model State Drug Laws (the "President's Commission"). The President's Commission, which was established by the United States Congress in the early 1990's, was charged with a number of missions, including the creation of a model code of laws that would help states effectively address alcohol and drug abuse and addiction. *See* PRESIDENT'S COMMISSION ON MODEL STATE DRUG LAWS – TREATMENT at 1 (1993) (hereinafter "PRESIDENT'S COMMISSION - TREATMENT"). The National Alliance continues the work of the President's Commission.

The National Alliance has an interest in this matter because it has concluded that it is vital to preserve the rights of states to pursue effective and cost-saving policy solutions with respect to drug and alcohol control laws.[1]

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[1] No counsel for any party authored this brief, in whole or in part, and no person or entity other than the National Alliance has made a monetary contribution to the preparation or submission of this brief. This *Amicus Curiae* brief is filed pursuant to the written blanket consents that have been filed by the parties.

SUMMARY OF ARGUMENT

The National Alliance urges caution, when this Court considers the preemptive reach of ERISA. States are, and must continue to be, free to adopt effective and cost-effective drug laws and health laws, and this necessarily includes measures to enforce those laws, lest those laws become empty gestures.

ARGUMENT

I. This Court Has Repeatedly Acknowledged the Rights of States to Make Health Policy Decisions.

This Court has in the past consistently preserved the rights of states to enact and enforce those laws that states deem necessary to protect the rights of their citizens. This is particularly true of state laws in the field of health care. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) ("[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose."); *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985) (state's mandatory mental-health benefit law not preempted by ERISA, except with respect to self-insured plans); *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003) (state any-willing-provider law not preempted by ERISA); *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002) (state independent-review law not preempted). The mission and mandate of the National Alliance include not only the study of diseases of addiction, but also the consideration and creation of policy solutions, many of which are embodied in Model State Drug Laws, which were first promulgated by the President's Commission and are now promoted by the National Alliance. This Court's prior decisions have afforded states the policy space to create, pursue, and enforce such solutions, and the National Alliance urges the Court to preserve the freedom of the states in this area.

II. The Benefits of Addiction Treatment

A. Treating Diseases of Addiction Saves Money, Furthers Public Health and Safety, and Is Sound Policy.

Diseases of addiction afflict a significant percentage of the population in this country. For example, a review article in the New England Journal of Medicine reported that "epidemiologic studies in the United States estimate the prevalence of alcohol abuse and dependence in the past year as 7.4 percent to 9.7 percent, and the lifetime prevalence as 13.7 percent to 23.5 percent." Patrick O'Connor, M.D., M.P.H. & Richard J. Schottenfeld, M.D., *Patients with Alcohol Problems*, 338 NEW ENGLAND JOURNAL OF MEDICINE 592, 593 (Feb. 26, 1998) (citations omitted). Diseases of addiction can devastate not only the lives of those directly afflicted, but also the lives of others with whom they share homes, workplaces, cities, and roadways.

Those suffering from diseases of addiction, and their families, use health care (and incur health care costs) at rates significantly higher than the general population. According to a comprehensive review article prepared for the President's Commission, "[i]n contrast to non-alcoholics, alcoholics usually incur health care costs that are at least 100% higher, and in the last twelve months before treatment of addiction, the costs are close to 300% higher." CENTER FOR ALCOHOL STUDIES, SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT at i (1993). This increased health care utilization includes use by family members: "[p]olicyholders in alcoholic families use[] roughly twice the [health care] services of nonalcoholic families." *Id.* ch. 4 at 21. Of course, many of the social and economic costs of addiction are then borne by the health care system itself, and by government.

When diseases of addiction are treated, however, health care costs are markedly reduced, for both addicts and their families. SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT at i, ch. 4 at 26; *see also* Stephen P. Melek, Research Report: Behavioral Healthcare Risk-Sharing and Medical Cost Offsets 8 (Milliman & Robertson 1996) (describing "important evidence that treatment initiation may result in a decline in overall [health care] costs"), *available at* http://www.milliman.com/health/publications/ research_reports /hr_13.pdf. Thus, treating diseases of addiction is an important and effective way to control health care spending.

Equally significantly, perhaps of paramount importance, treating diseases of addiction is an important way to control and limit the social costs that are imposed on society by these diseases. Roughly 80% of those incarcerated in this country are either chemically dependent or serving time for a crime committed while under the influence of drugs or alcohol. Furthermore, according to a report from the United States Department of Health and Human Services, treating someone suffering from a disease of addiction causes a 79% reduction in crimes that would otherwise be committed by the individual, and therefore a 79% reduction in the costs associated with crime. CENTER FOR SUBSTANCE ABUSE TREATMENT, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, FINAL REPORT, NATIONAL TREATMENT IMPROVEMENT EVALUATION STUDY at 241 (1997), *available at* http://www.icpsr.umich.edu/SAMHDA/NTIES/NTIES-PDF/ ntiesfnl.pdf. Treatment for drug and alcohol addiction is also one of the most cost-effective tools in the nation's continuing struggle to reduce and eliminate the market for illegal drugs. *See* C. Peter Rydell and Susan S. Everingham, Controlling Cocaine: Supply Versus Demand Programs (Rand 1994).

B. Addiction Treatment Services Are Underutilized.

Addiction treatment services are frequently underutilized – that is, in the aggregate those afflicted with diseases of addiction seek and receive treatment at a level that falls far below the level that would provide the greatest cost savings. Diseases of addiction are, by their very nature, characterized by denial, and often carry a strong social stigma. Many who need treatment do not seek it, or do not seek it early enough. As noted in the White House's most recent National Drug Control Strategy report, "according to a survey by the Department of Health and Human Services, the overwhelming majority of drug users who need treatment fail to recognize it .... Of the estimated five million individuals who needed but did not receive treatment in 2001, fewer than 8 percent felt they actually needed help." THE WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY 18 (Feb. 2003). There is therefore a "crucial need to get people into treatment – no small matter when dealing with an illness whose core characteristic is denial." *Id.* As the 1993 President's Commission concluded, the underutilization of addiction treatment services "perpetuates the health care spending on addiction related accidents and illness and limits capturing of health care savings through the treatment of the primary illness." PRESIDENT'S COMMISSION – TREATMENT at 81.

This is one reason why the National Alliance's Model Laws, and the laws of many states, *require* treatment as part of the criminal justice system. *See, e.g.*, MODEL CRIMINAL JUSTICE TREATMENT ACT §§ 5-8, set forth in PRESIDENT'S COMMISSION – TREATMENT at 151-61 (providing for court-ordered assessment and treatment, for offenses involving drugs or alcohol); *see also* 2003 Pa. Legis. Serv. Act 2003-24 § 16 (West) (to be codified at, *inter alia*, 75 Pa. Cons. Stat. §§ 3814-

15) (mandatory treatment after a repeat conviction for drunk driving); 625 ILL. COMP. STAT. ANN. § 5/11-501(e) (court-imposed treatment after drunk driving conviction). It is also one important reason why many states have enacted laws that require health insurers to provide or make available coverage for addiction treatment.[2]

The same factors that drive underutilization also mean that managed care missteps, or misconduct, have the potential for enormous adverse consequences. For example, a person with an alcohol problem who is beginning to experience the physical symptoms of withdrawal is not likely to remain in a treatment center's waiting room for hours, while awaiting a precertification decision from a managed care company. And an addict who seeks treatment one day may – if the treatment does not start that day – return to active use and active addiction. A stark and particular example of this is found in the facts underlying *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997). The relationship between managed care and addiction treatment has also been noted in the policy literature. *See, e.g.*, Shelley Steenrod *et al., Effects of Managed Care on Programs and Practices for the Treatment of Alcohol and Drug Dependence*, 15 RECENT DEVELOPMENTS IN ALCOHOLISM 51, 67 (2001) ("Our review of managed care's influences on alcohol and drug abuse treatment systems finds

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[2] *See, e.g.*, HAW. REV. STAT. § 393-7(c)(6) (1993); 215 ILL. COMP. STAT. ANN. § 5/367(7) (West 1992); MD. CODE ANN. INS. § 15-802 (2002); MICH. COMP. LAWS ANN. § 500.3425(1) (2002); MISS. CODE ANN. §§ 83-9-27 to -31 (1972); N.J. STAT. ANN. § 17B:26-2.1 (1996); OHIO REV. CODE ANN. § 3923.29 (Anderson 2002); 40 PA. CONS. STAT. ANN. §§ 908-1 to -8 (1999); S.C. CODE ANN. § 38-71-737 (2002); TEXAS INS. CODE ANN. § 3.51-9 (Vernon Supp. 2004); *see also* MODEL ADDICTION COSTS REDUCTION ACT §§ 1-14, set forth in PRESIDENT'S COMMISSION – TREATMENT at 23-29 (requiring addiction treatment coverage).

evidence of systemic reductions in access to inpatient care and increased reliance on outpatient services.").

When an opportunity for effective treatment is lost, it is often the states that bear the burden. Most directly, this often results in a cost shift from private insurers to public funding sources, imposing costs on both publicly funded treatment resources and the criminal justice system. As set forth in PRESIDENT'S COMMISSION – TREATMENT, in the section addressing managed care:

> Cost shifting is already occurring here. In some cases, treatment already covered by insurance and paid for by the patient or the patient's employer is being shifted to public funding sources such as Medicaid, block grant monies and other state funding. Others go untreated altogether with the predictable societal costs of increased medical expenses, lost jobs with resulting unemployment and welfare costs, broken families and ultimately, crime.

PRESIDENT'S COMMISSION – TREATMENT at 82.

For these reasons, states have occasion to be extremely vigilant about any barriers to addiction treatment, including barriers that may be presented by managed care. In recognition of the direct effect that managed care decisions can have on a patient's course of addiction treatment, some states have enacted laws that not only require an addiction treatment benefit, but also impose requirements on the procedures and standards of the managed care organizations that decide whether or not the insured will receive care in a particular instance. Pennsylvania's law, for example, has been interpreted by its Insurance Commissioner as placing treatment placement decision in the hands of a treating physician, not the

managed care organization. Pennsylvania Department of Insurance Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003); *see* 40 Pa. Cons. Stat. Ann. § 908-4 (1999). For another example, the Model State Laws promulgated by the National Alliance require that managed care organizations use particular criteria and establish and follow certain specified procedures. MODEL MANAGED CARE CONSUMER PROTECTION ACT §§ 1-19, set forth in PRESIDENT'S COMMISSION – TREATMENT at 87-95; *see also*, *e.g.*, MD. CODE ANN. INS. § 15-10B-07 (2002) (qualification standards for utilization review physicians making substance abuse treatment decisions).

If states are permitted to endorse or pursue these policy protections, they should also be permitted to enforce them. Otherwise, these laws risk becoming empty gestures. This concern is not chimerical, as demonstrated by the numerous voices raising concerns about the effect that managed care has had on access to addiction treatment, even in states with powerful mandated-benefit laws. *E.g.*, LEGISLATIVE BUDGET AND FINANCE COMMITTEE, PENNSYLVANIA GENERAL ASSEMBLY, DRUG AND ALCOHOL TREATMENT SERVICES IN A MANAGED CARE ENVIRONMENT 16-25, 25 (Feb. 2003) (noting that the involvement of commercial managed care has resulted in shorter residential treatment stays, and observing that "it is clear that the average lengths of stay for inpatient rehabilitation . . . do not begin to approach the minimum coverage provisions (30 days) set forth in [40 Pa. Stat. Ann. § 908-4]"); Steenrod *et al, supra*.

The National Alliance is not, of course, asking this Court to take a position on the numerous policy issues discussed in the preceding paragraphs. Rather, the point is that these are serious policy drivers that are supported by significant evidence, and state legislators and state courts are, and should

continue to be, guided by their own analysis of the evidence, their own conclusions, and their own solutions.

III. The Relationship Between Diseases of Addiction and ERISA Preemption

Diseases of addiction, and the policy issues referred to above, shine an important light on two facets of the issue now before the Court.

First, and most fundamentally, the supposed cause-and-effect relationship between care that is actively managed by an insurer and lower health care costs is not as straightforward as Petitioners and their *amici* suggest. It is not universally true that every effort to expand medical treatment will increase health care expenditures. Quite to the contrary, effective drug and alcohol addiction treatment will on balance save health care costs, and also save society significant other costs.

Second, the experience with diseases of addiction demonstrates that managed care health insurers are not always in the best position, or even in a good position, to make utilization review decisions that result in the lowest health care costs. If this were so – and if the policy literature referred to above is correct – the managed care industry would readily embrace effective addiction treatment, and there would be no need for any state, ever, to mandate coverage for such treatment. That plainly has not happened, and state governments have found it necessary to require such coverage.

In order to understand one of the possible reasons why there may be a disconnect between the health care cost benefits of addiction treatment and a health insurer's posited motivation to lower health care costs, it is important to consider in more detail the structure of how behavioral health benefits are usually managed. Behavioral health care (a category that

frequently includes addiction treatment) is "very often identified and treated differently – mostly through behavioral carve-out or carve-in arrangements." Melek, *supra*, at 4. Thus, these medical decisions will be made not by the HMO or managed care insurer, but by another company that has contracted with the HMO or managed care insurer to make those decisions. "The behavioral healthcare organization is frequently capitated on a PMPM [per member per month] basis with **no** provision for risk sharing with the medical side of healthcare delivery." Melek, *supra*, at 4 (emphasis in original). As a result the entity making medical decisions that determine whether or not a patient receives addiction treatment (and determines what treatment they receive, how much of it, in what setting, and when) is often not in a position to reap the financial benefits that would eventually inure to the health insurer in the form of reduced medical care costs for the addict and his or her family. To the contrary, the decision maker stands only to reap the more direct economic benefits that any capitated provider receives by providing **less** care. *See generally Pegram*, 530 U.S. at 218-221. One researcher, analyzing the results from a single large employer, found that following the shift from HMO's to a single behavioral health carve-out contractor, the use of inpatient addiction treatment services per 1,000 members declined from 10.6 before the transfer to a carve-out contractor, to 5.5 in the first year after the carve-out, to 2.5 in the second year. Bradley Stein, M.D., M.P.H., *et al., Substance Abuse Utilization under Managed Care: HMOs Versus Carve-Out Plans*, 26 JOURNAL OF BEHAVIORAL HEALTH SERVICES & RESEARCH 451, 452 (1999).

Furthermore, many of the costs of addiction are borne not by the health insurer at all but rather shifted to society as a whole. This makes it even less certain that managed care insurers will, on their own, inevitably make those decisions that best serve the public health and safety interests referred to above.

Again, the National Alliance is not asking the Court to endorse any particular view on the economics of health care. Rather, the National Alliance seeks to alert the Court that these are difficult and important policy issues that states must be free to consider, evaluate, and respond to as they see fit.

IV. This Court Should Not Foreclose the Rights of States To Enact and Enforce Effective Drug Control Laws.

The National Alliance urges caution when the Court considers the scope of preemption under ERISA section 502.

Petitioner Aetna, in particular, advances a newly expansive interpretation of preemption under ERISA section 502, 29 U.S.C. § 1132, which could drastically curtail the range of policy options available to states. Petitioner Aetna is quite candid about this: under its interpretation of section 502 states can pass addiction treatment laws but are, whenever an ERISA plan is involved, extremely limited in their ability to enforce them. "[W]here the States are foreclosed from regulating is in prescribing additional *remedies* for breach of those state-mandated obligations." Petitioner Aetna's Brief at 47 (emphasis in original). This cannot and should not be the law, and such a broad holding here would be inconsistent with the earlier pronouncements of this Court.

As this Court stated in *Pegram*, "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." 530 U.S. at 236. No such purpose can be found here. Section 502 does not even mention, let alone preempt, substantive legal rights that exist outside of and independent of ERISA. Consequently, preemption of a state's right to pursue and **enforce** important public policy choices would also be improper.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) have been addressed extensively in the briefs of Petitioners and will doubtless be covered in the brief of Respondent. For present purposes, it is sufficient to emphasize the factual context of those cases: both clearly revolved around a claim for benefits, not substantive rights that were established by state law and existed independent of any ERISA plan. *See Metropolitan Life*, 481 U.S. at 61 (the relief that plaintiff was seeking in his complaint included "reimplementation of all benefits"), *Pilot Life*, 481 U.S. at 43 (referring to the plaintiff's "state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan"). Interpreting those decisions in a manner that would foreclose meaningful state regulation of managed care, and that could potentially foreclose state policy choices in this important area, is a result that is not dictated by those decisions and is not supported by the principles or statutory provisions that underlie them.

CONCLUSION

For the reasons set forth above, the National Alliance urges an interpretation of ERISA preemption that allows states to proceed with their efforts to fashion cost-effective, and effective, drug control policy.

Respectfully submitted,

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Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, *et al.*,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF COMMUNITY RIGHTS COUNSEL AND THE BRENNAN CENTER FOR JUSTICE AT NEW YORK UNIVERSITY SCHOOL OF LAW AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*[1]

Community Rights Counsel (CRC) is a nonprofit, public interest law firm that assists state and local officials in defending community protections through the promotion of federalist principles. For example, CRC has submitted *amicus curiae* briefs on behalf of state and local officials arguing against overly expansive readings of the Fifth Amendment in cases involving state funding mechanisms for legal services for the poor, *see Brown v. Legal Found. of Wash.*, 538 U.S. 216 (2003), and protections for natural resources. *See Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 535 U.S. 302 (2002). More recently, CRC has filed *amicus* briefs with this Court in preemption challenges to state and local protections of public health and the environment. *E.g.*, *Engine Mfrs. Ass'n v. South Coast Air Quality Mgmt. Dist.*, No. 02-1343; *Eyl v. Ciba-Geigy Corp.*, No. 02-1500; *City of Lodi v. Firemen's Fund Ins. Co.*, No. 02-1169.

The Brennan Center for Justice at New York University School of Law is a nonpartisan organization that unites scholarship, public education, and legal action to find innovative and practical solutions to intractable problems in the areas of democracy, poverty, and criminal justice. Its Fair Courts Project, part of the Brennan Center's Democracy Program, addresses issues like

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[1] Counsel for the parties did not author this brief in whole or in part. No person or entity other than the *amici*, their members, and their counsel made a monetary contribution to the preparation or submission of this brief. Petitioners and respondents have consented to the filing of *amicus* briefs in letters filed with the Clerk.

judicial independence, access to the courts, and the relationship among federal, state, and local power.

CRC and the Brennan Center have a strong interest in this case because it raises fundamental questions about the role of state courts in our federal system and their ability to address claims by their citizens who allege they have been wronged under state law.

PRELIMINARY STATEMENT AND SUMMARY OF ARGUMENT

Petitioners' submissions (Aetna Br. 40-50, Cigna Br. 42-50) contain considerable verbiage contending that our nation's health care system would be better off by eliminating state-law actions against managed care organizations for negligent "medical necessity" determinations. The Court need not resolve this complex policy issue here.

The question presented is jurisdictional: Who decides? Does § 502(a) of the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a), prevent state courts from exercising jurisdiction over a suit filed under state law challenging a medical necessity determination and then deciding, subject to review by this Court, whether the action may proceed in the face of the express preemption provision in § 514? In other words, has Congress, through § 502(a), incapacitated the state courts from playing any role in resolving the preemption matter?

Someday, this Court might be called upon to decide, under principles of express and conflict preemption, whether ERISA preempts suits like those at issue here. But that question need not be answered in this case.

Indeed, in a separate ruling (nowhere mentioned in petitioners' merits briefs), the Fifth Circuit reluctantly concluded that it was bound by outdated circuit precedent to rule that § 514 does preempt such suits, precedent it now correctly believes has been severely undermined and should be reconsidered. Cigna Pet. App. 24a-28a. Yet the Fifth Circuit simultaneously held that the more demanding standards of removal under § 502 do not authorize complete preemption of such suits (*id.* at 7a-20a), thereby demonstrating the independence of these two matters. *Accord, Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 26-27 (1983) (holding that state-law actions can be preempted by ERISA but not subject to complete preemption under § 502).

At times, petitioners seem to suggest that every claim preempted by ERISA is subject to complete preemption and removal under § 502. *E.g.*, Cigna Br. 5-6. But *Franchise Tax Board* and this Court's other precedents demonstrate that this is emphatically untrue.

As shown in Section I below, complete preemption – a variant of what is commonly called the artful pleading doctrine – is a narrow exception to the well-pleaded complaint rule, which authorizes removal of a suit from state to federal court *only* where the action could have been brought in federal court under federal law. This Court has never found complete preemption outside the narrow context in which the plaintiff's claim was actually a claim that could have been filed under federal law. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), for example, the Court ruled that removal was proper under § 502 of ERISA where an employee sued in state court under state contract law for, among other things, breach of the applicable ERISA plan due to an improper processing

of benefits, a benefits claim that plainly could have been brought directly under ERISA in federal court.

In Section II, we show that respondents' claims could not have been filed under ERISA. Their complaints do not allege improper processing of benefits, and they do not seek benefits under the applicable ERISA plans. Instead, they seek appropriate damages under state law based on allegedly negligent medical necessity determinations, claims rooted in a state statute that is entirely independent from ERISA and in no way depends on an interpretation or application of respondents' ERISA plans. *Franchise Tax Board* is controlling, and because respondents' claims could not have been filed under ERISA, they are not subject to complete preemption.

ARGUMENT

This is a case about federalism, *i.e.*, the appropriate constitutional role of the States in our federal system. By so stating, we do not mean to minimize respondents' plight. They allege they suffered serious physical injury and unnecessary pain due to medical necessity decisions by petitioners that did not meet the basic standard of ordinary care under the Texas Health Care Liability Act.

The issue at hand, however, should turn on this Court's respect for the authority and responsibility of state courts to address such claims. As Justice Black famously put it, Our Federalism requires "a proper respect for state functions, a recognition of the fact that the entire country is made up of a Union of separate state governments, and a continuance of the belief that the National Government will fare best if the States and their institutions are left

free to perform their separate functions in their separate ways." *Younger v. Harris*, 401 U.S. 37, 44-45 (1971).

Although Our Federalism implicates a wide array of legal doctrines, scholars recognize that the proper limitation of preemption is one of the most important aspects of federalism because preemption directly affects the States' ability to provide services and beneficial regulation to their citizens. *See* Ernest A. Young, *Two Cheers for Process Federalism*, 46 VILL. L. REV. 1349, 1377-80 (2001). In the same vein, Justice Breyer recently concluded:

> [T]he true test of federalist principle may lie, not in the occasional constitutional effort to trim Congress' commerce power at its edges, or to protect a State's treasury from a private damages action, but rather in those many statutory cases where courts interpret the mass of technical detail that is the ordinary diet of the law.

Egelhoff v. Egelhoff, 532 U.S. 141, 160-61 (2001) (citations omitted) (Breyer, J., joined by Stevens, J., dissenting); *cf. Geier v. American Honda Motor Co.*, 529 U.S. 861, 887 (2000) (Stevens, J., joined by Souter, Thomas, & Ginsburg, JJ., dissenting).

Sensitive issues of federalism are especially evident in cases like this one that involve the artful pleading doctrine because they are predicated on federal-question jurisdiction under 28 U.S.C. § 1331, which "masks a welter of issues regarding the interrelationship of federal and state authority." *Franchise Tax Board*, 463 U.S. at 8. While a proper interpretation of § 502 certainly implicates a "mass of technical detail," affirmance here is compelled by both a straightforward application of principles governing

removal and a proper respect for the appropriate role of state courts in our federal system.

In assessing the propriety of removal of a case from state to federal court, a "State's dignitary interest bears consideration." *Ruhrgas AG v. Marathon Oil Co.*, 526 U.S. 574, 576 (1999); *accord*, *Healy v. Ratta*, 292 U.S. 263, 270 (1934) ("Due regard for the rightful independence of state governments * * * requires that [federal courts] scrupulously confine their own jurisdiction to the precise limits which the statute has defined."). The mere notice of removal strips the state court of jurisdiction to take any further action in the case, subject only to the discretion of a federal district judge. *See* James C. Rehnquist, *Taking Comity Seriously: How to Neutralize the Abstention Doctrine*, 46 STAN. L. REV. 1049, 1087-88 (1994) ("A state court that has a case snatched from its docket has a legitimate cause for offense. More than insult, this is injury – a result that renders fruitless a previous investment of scarce resources.").

We show below that the Fifth Circuit paid proper respect to the appropriate role of state courts in our federal system by concluding that respondents' claims do not arise under ERISA and thus are not removable to federal court.

I. A STATE-COURT ACTION RAISING ONLY STATE-LAW CLAIMS THAT CANNOT BE PURSUED UNDER ERISA DOES NOT "ARISE UNDER" ERISA FOR PURPOSES OF REMOVAL.

The standards for removing a case to federal court are more than a century old. A state-court action may be removed to federal court only if it qualifies as a "civil

action * * * of which the district courts of the United States have original jurisdiction." 28 U.S.C. § 1441(a). Removal is "entirely a creature of statute," *Syngenta Crop Prot., Inc. v. Henson*, 537 U.S. 28, 28 (2002), and "these statutory procedures for removal are to be strictly construed." *Id.* at 32.

The only possible basis for removal in this case is federal-question jurisdiction, which gives district courts the authority to preside over "[a]ny civil action * * * founded on a claim or right arising under the Constitution, treaties or laws of the United States." 28 U.S.C. § 1441(b); *see also* 28 U.S.C. § 1331. The presence or absence of federal-question jurisdiction depends on an examination of the "well-pleaded" allegations on the face of a state court complaint. *See Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062 (2003); *Gully v. First Nat'l Bank in Meridian*, 299 U.S. 109, 112-113 (1936). Defenses, including a defense based on the preemptive effect of federal law, do not provide a basis for federal-question jurisdiction. *See Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 14 (1983) ("a case may not be removed to federal court on the basis of a federal defense * * * even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case.").

Thus, complaints such as those filed by respondents, which raise only state-law claims, generally cannot be removed from state to federal court. Removal here depends on the "artful pleading" doctrine and a subspecies of that doctrine known as "complete preemption." *See Rivet v. Regions Bank of La.*, 522 U.S. 470, 475 (1998) ("The artful pleading doctrine allows removal where federal law

completely preempts a plaintiff's state-law claim."). The doctrine of complete preemption, or more accurately removal preemption,[2] originated in Justice Douglas's opinion for the Court in *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), which stands for the proposition that the preemptive force of certain federal statutes is sufficient to displace entirely state-law actions that, in substance, assert claims maintainable under federal law. Thus, in *Avco*, the Court permitted removal of a state-law claim for violation of a contract between an employer and a labor organization on the ground that these claims could be brought only under § 301 of the Labor Management Relations Act (LMRA). As the Court explained last Term in *Beneficial National Bank*, "[w]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." 123 S. Ct. at 2062.

The standard for permitting removal based on the artful pleading doctrine is distinct from, and more demanding than, the question of whether ERISA preempts state law. As the *Franchise Tax Board* Court explained, "[m]erely to hold that ERISA does not have the same effect on appellant's suit in this case that § 301 of LMRA had on the petitioner's contract suit in *Avco* is not to prejudge the merits of [the] preemption claim." 463 U.S. at 27; *id.* at 26 (rejecting removal even though "the Court of Appeals may

[2] Courts use the terms "complete preemption" and "removal preemption" interchangeably. *See Russell v. Sprint Corp.*, 264 F. Supp. 2d 955, 961 (D. Kan. 2003). We do so as well.

well be correct that ERISA precludes enforcement of the State's levy in the circumstances of this case").

To date, this Court has permitted removal under the complete preemption doctrine only where at least one claim brought in state court paralleled a federal claim and thus could have been brought originally in federal court. In *Avco*, for example, the employer's state-law claim sought to enforce a no-strike clause of a collective bargaining agreement, a claim at the very heart of the area preempted by § 301 of the LMRA. Similarly, in *Metropolitan Life*, this Court's only case to date that allows removal under ERISA, the claimant sought, among other relief, "money contractually owed" under the terms of Metropolitan Life's ERISA plan. 481 U.S. at 61. The *Metropolitan Life* Court permitted removal of the state-law contract claim because the claim was "by a beneficiary to recover benefits from a covered plan," an action that "falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63. Because the contractual claim for ERISA benefits supported removal, the *Metropolitan Life* Court had ample authority to exercise jurisdiction over the plaintiff's other contract and tort claims without an independent analysis of whether those claims would support removal. *See* 28 U.S.C. § 1441(c).

Other precedents confirm that removal preemption is limited to claims that could have been brought under federal law notwithstanding the complaint's failure to refer to that law. *Compare Beneficial Nat'l Bank*, 123 S. Ct. at 2063 (permitting removal of a state-law claim against a national bank because the complaint "expressly charged petitioners with usury," a claim that could have been filed under federal law), *with Caterpillar Inc. v.*

Williams, 482 U.S. 386, 397 (1987) (rejecting removal under § 301 of the LMRA where the claim was based on an alleged individual employment contract that pre-existed a collective agreement and thus could not have been filed under § 301).

The Court's unanimous ruling in *Rivet* explains why removal on the basis of complete preemption is appropriate only where the state-law claims at issue could actually be brought in federal court. In *Rivet*, Regions Bank attempted to remove a state-law claim to federal court on the ground that the claim was precluded as a matter of federal law by an earlier federal court ruling. The Court rejected this proposed extension of the artful pleading doctrine, expressly distinguishing complete preemption cases:

> A case blocked by the claim preclusive effect of a prior federal judgment differs from the standard case governed by a completely preemptive federal statute in this critical respect: The prior federal judgment does not transform the plaintiff's state-law claims into federal claims but rather extinguishes them altogether. Under the well-pleaded complaint rule, preclusion thus remains a defensive plea involving no recasting of the plaintiff's complaint, and is therefore not a proper basis for removal.

522 U.S. at 476-77 (citation omitted).

The rule of *Rivet* is that the artful pleading exception to the well-pleaded complaint doctrine is viable only where the state-court claim could actually be maintained under federal law. Where a claim cannot be brought under federal law, a successful defense that a state claim is preempted by federal law would extinguish the claims

altogether. In such cases, preemption involves no recasting of the plaintiff's complaint, and there is no proper basis for removal.

II. RESPONDENTS' ACTIONS CANNOT BE PURSUED UNDER ERISA.

Section 502(a)(1)(B) authorizes suits by ERISA plan participants and beneficiaries to recover benefits due under the plan, and to enforce and clarify rights under the plan. 29 U.S.C § 1132(a)(1)(B). Through their state court lawsuits, respondents seek none of these things. Their claims are rooted in a state statutory duty of ordinary care that is entirely independent of ERISA and the obligations imposed thereunder. The elements respondents must establish to prevail on their claims and obtain the relief they seek have nothing to do with the enforcement of ERISA rights or the collection of plan benefits.

Respondents thus stand in stark contrast to the plaintiff in *Metropolitan Life*, who alleged an "improper processing of a claim for benefits" (481 U.S. at 60) and sought "reimplementation of all benefits and insurance coverages" (*id.* at 61). Similarly, the complaint in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), expressly challenged a termination of disability plan benefits, and the complaint requested "[d]amages for failure to provide benefits" under an ERISA plan. *Id.* at 43.[3] Respondents

[3] Although petitioners rely heavily on *Pilot Life*, that case did not involve removal preemption under § 502, but instead express preemption under § 514. To be sure, *Pilot Life* discusses § 502 in the course of analyzing preemption under § 514, but only because the claim sought relief due to an allegedly improper denial of benefits, a claim that could

(Continued on following page)

neither allege improper processing nor seek reinstatement of benefits. Thus, their claims do not arise under ERISA.

The Court's unanimous ruling in *Franchise Tax Board* is controlling on this point. There, a California tax authority filed suit in state court to enforce a tax levy against funds held in trust pursuant to an ERISA-covered employee benefit plan, and for a declaration that the trustees were required to honor future levies. The trust removed to federal court, arguing that under *Avco,* California's claims were "in substance" federal claims because they were within the scope of, and thus removable under, § 502. 463 U.S. at 22. The Court rejected this argument, holding that the claims were not within the scope of § 502. *Id.* at 22-28.

In analyzing the levy enforcement claim, the Court anticipated its subsequent ruling in *Metropolitan Life*, acknowledging that "[i]t may be that * * * any state action coming within the scope of § 502(a) of ERISA would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without

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have been brought directly under § 502. *See Pilot Life*, 481 U.S. at 43 (articulating the question presented as whether ERISA preempts state actions "asserting improper processing of a claim for benefits under an insured employee benefit plan" and describing the claims as seeking "[d]amages for failure to provide benefits under the insurance policy"); *id.* at 51-52 (concluding that § 502 was relevant to the § 514 issue "[b]ecause in this case, the state cause of action seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan."); *id.* at 57 (concluding "that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)."). As shown herein, respondents' claims under the Texas Health Care Liability Act are independent of ERISA and could not have been brought under § 502. *Pilot Life* is thus plainly distinguishable.

reference to federal law." 463 U.S. at 24. The Court went on to make clear, however, that such a ruling would not mean that any claim seeking funds from, or otherwise related to, an ERISA plan would justify removal.

Specifically, the *Franchise Tax Board* Court cast the complete preemption issue as whether California's claims were, "in substance," ERISA claims notwithstanding the state's failure to plead an ERISA claim. *Id.* at 22. This issue reduced to an inquiry into whether California had tried to "defeat removal by omitting to plead *necessary* federal questions in [its] complaint." *Id.* (emphasis added). After examining § 502 in detail, the Court concluded that California had not omitted any necessary federal questions because "on the face of a well-pleaded complaint there are many reasons completely unrelated to the provisions and purposes of ERISA why the State may or may not be entitled to the relief it seeks." *Id.* at 26. For example, the Court observed that "[i]n theory (looking only at the complaint), it may turn out that the levy was improper under state law, or that in fact the defendant had complied with the levy." *Id.* at 26 n.29. The Court distinguished *Avco* by stressing that "[u]nlike the contract rights at issue in *Avco,* the State's right to enforce its tax levies is not of central concern to the federal statute," even though California's levy suit sought to raid the coffers of an ERISA-sponsored plan. *Id.* at 25-26.

In the same way, respondents' complaints do not omit "necessary" federal questions because their state statutory claims against petitioners do not require interpretation of ERISA or their ERISA plans. As in *Franchise Tax Board*, respondents' claims might well fail or succeed for reasons entirely independent of ERISA, including a failure to prove the requisite elements of a claim under the Texas

Health Care Liability Act, elements that have no cognates in a § 502 claim. And as in *Franchise Tax Board*, respondents' suits as pleaded do not "arise under" ERISA simply because respondents are subject to ERISA plans administered by respondents. Nor is the Texas state statutory duty of medical care a central concern of ERISA. *See* pages 16-18, below (discussing *Pegram*). Of course, to apprehend the basic nature of respondents' claims, the Texas courts on remand would need to acknowledge the obvious fact that respondents are challenging medical necessity determinations. But this is no different from *Franchise Tax Board*, where a basic understanding of California's claim required acknowledgment that its levy was asserted against an ERISA plan whose members included delinquent taxpayers. In neither case would a court need to interpret and apply the plan to resolve the claim.

Another passage of the *Franchise Tax Board* opinion drives this conclusion home. In footnote 28 and the accompanying text, the Court contrasted § 502 of ERISA with § 301 of the LMRA, interpreted in *Avco,* and determined that § 301 is more encompassing with respect to suits related to employment contracts than § 502 is with respect to ERISA plans. *Id.* at 25 n.28. It nonetheless concluded that "even under § 301, we have never intimated that any action merely relating to a contract within the coverage of § 301 arises exclusively under that section." *Id.* For example, "a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract." *Id.* at 25 n.28. In the same way, a state tort suit challenging the negligent act of a managed health care organization

does not arise under ERISA simply because the injured employee is subject to an ERISA plan.

To be sure, in analyzing California's declaratory judgment action, the *Franchise Tax Board* Court provided a second basis for distinguishing *Avco* and ruling against removal, namely that § 502 provides a cause of action only to plan participants, beneficiaries, and fiduciaries, not to the State of California. *Id.* at 26-27. Although this ground for finding no removal would not apply to respondents here, the Court's analysis makes clear that removal is inappropriate where either one of the distinguishing features exists, *i.e.*, either where the state action is independent from ERISA or where the plaintiff is not a plan participant, beneficiary, or trustee. *Id.*

Franchise Tax Board, which receives only a single passing reference by petitioners (Aetna Br. 23-24), is fully consistent with *Metropolitan Life*. As mentioned above, *Franchise Tax Board* expressly anticipated the *Metropolitan Life* ruling, handed down just four years later. Last Term, this Court reaffirmed both *Franchise Tax Board* and *Metropolitan Life*. *See Beneficial Nat'l Bank*, 123 S. Ct. at 2062-63 (relying on *Franchise Tax Board*, *Avco*, and *Metropolitan Life* to "provide[ ] the framework" for analyzing removal preemption). Taken together, these rulings instruct federal district courts (1) to allow removal where a state-court action seeks to enforce or clarify rights under an ERISA plan and thus could have been filed in federal court under § 502 (notwithstanding the absence of any reference to ERISA), and (2) not to remove state court actions that do not seek to clarify obligations arising

directly from an ERISA plan, but rather attempt to vindicate rights from an independent source that would not require interpretation of ERISA or an ERISA plan.[4]

The distinct nature of respondents' suits under the Texas Health Care Liability Act is confirmed by the Court's unanimous ruling in *Pegram v. Herdrich*, 530 U.S. 211 (2000). We will not burden the Court with another lengthy description of this case. But it bears repeating that *Pegram* concludes that Congress did not intend to federalize state-law malpractice claims by allowing them to be brought as fiduciary claims under § 502(a)(2). *Id.* at 236. This conclusion has direct relevance to the removal issue under § 502, for as the U.S. Court of Appeals for the Eleventh Circuit determined, "it makes little sense to

[4] *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399 (1988), a LMRA preemption case, reinforces this argument. The *Lingle* Court held that § 301, which preempts suits arising out of union contracts, did not preempt a state-tort claim for wrongful termination, even though the union contract at issue limited discharges to "just cause." *Id.* at 406-13. The *Lingle* Court invoked state anti-discrimination laws as a helpful analogy to support its conclusion that Lingle's retaliatory discharge claim was independent from, and thus not preempted by, any potential claim for violation of the contract:

> [T]he mere fact that a broad contractual protection against discriminatory – or retaliatory – discharge may provide a remedy for conduct that coincidentally violates state law does not make the existence or the contours of the state law violation dependent upon the terms of the private contract. For even if an arbitrator should conclude that the contract does not prohibit a particular discriminatory or retaliatory discharge, that conclusion might or might not be consistent with a proper interpretation of state law.

Id. at 412-13. Likewise, a ruling by a state court on respondents' claims would rely exclusively on state statutory law and be entirely independent from obligations arising under ERISA.

believe that Congress did not intend to federalize malpractice claims under section 502(a)(2) [as held in *Pegram*], but intended to do so under section 502(a)(1)(B)" by requiring that such claims be brought exclusively in federal court as an ERISA claim to recover benefits. *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1293 (11th Cir. 2003), *petition for cert. filed* (No. 03-649, Oct. 28, 2003).

Petitioners seek to distinguish *Pegram* by noting that the treating physicians there owned the defendant-HMO and thus made the mixed eligibility-treatment decisions alleged to have been negligent. But the *Pegram* Court made clear that its analysis turned not on who made the decisions, but instead on the nature of the decisions being made:

> [Treatment and eligibility] decisions are often practically inextricable from one another. * * * This is so not merely because, under a scheme like [the HMO at issue], treatment and eligibility decisions are made by the same person, the treating physician. *It is so because a great many and possibly most coverage questions are not simple yes-or-no questions* * * * .

Id. at 228 (emphasis added; citation and footnote omitted). In practical terms, the Court continued, such eligibility decisions cannot be untangled from judgments about reasonable medical treatment. *Id.* at 229. This is true regardless of whether that decision is made by a treating physician who owns and operates an HMO, or by a desk nurse who exercises discretion on behalf of an HMO. Indeed, the Court stressed that its conclusion in this regard was not a narrow one limited to the relatively rare physician-owned HMO context, but instead extended to "countless medical administrative decisions [made] every day." *Id.*

Although *Pegram* is not directly controlling on removal, several federal appeal courts have received its message loud and clear, ruling that medical malpractice claims filed in state court are not claims arising under ERISA and thus are not subject to removal. *E.g.*, *Land*, 339 F.3d at 1289-94 (malpractice action filed in state court alleging that an HMO's failure to diagnose the plaintiff's condition correctly and authorize the proper treatment does not arise under ERISA and thus is not subject to removal); *Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003) (state-law malpractice action challenging a mixed eligibility/treatment decision does not arise under ERISA and is not removable to federal court), *petition for cert. filed* (No. 03-69, July 11, 2003)).

At bottom, the removal issue boils down to a proper notion of "artful pleading." *Franchise Tax Board*, *Metropolitan Life*, and this Court's other precedents governing removal preemption emphasize that the artful pleading prohibited by § 502 occurs where a plaintiff seeks to recover benefits due to a violation of an ERISA plan, but files a complaint based exclusively on state contract law without reference to ERISA. On those facts, the very contract being breached is an ERISA plan, and the state-law contract claim implicates the same evidence and legal analysis – including, notably, construction of the plan – that would attend a claim for benefits under § 502. Under those circumstances, the breach of contract claim really *is* an ERISA claim, and the plaintiff is not permitted to artfully plead around § 502's exclusive remedy scheme for the collection of benefits.

Petitioners essentially contend that § 502 prevents injured patients from filing in state court under state law *any* complaint against a plan administrator, regardless of

whether the patient seeks to recover plan benefits, or otherwise enforce or clarify rights and obligations under the plan. Their position is that *any* challenge to their allegedly negligent medical necessity decisions must be brought under § 502, regardless of whether resolution of the claim would involve an interpretation of ERISA or the applicable plans. Under this theory, even a state-law discrimination claim challenging a denial of benefits would be removable (*compare Lingle*, discussed in note 4, *supra*). This radical expansion of removal preemption finds no support in precedent and would constitute a frontal assault on the proper role of state courts in our federal system.[5]

CONCLUSION

To understand the scope and propriety of the Fifth Circuit's ruling, it is critical to distinguish the more demanding standards for removal under § 502 from those

[5] In *Beneficial National Bank*, Justice Scalia, joined by Justice Thomas, argued vigorously in dissent against the application of removal preemption beyond the limited facts of *Avco* and *Metropolitan Life*, calling the *Avco* ruling an "unprecedented act of jurisdictional alchemy." 123 S. Ct. at 2066 (Scalia J., dissenting). Petitioners' proposed expansion of removal preemption represents a far greater threat to state-court authority than that at issue in *Beneficial National Bank* because, in that case, the state-law usury claims were unquestionably preempted and thus there were "good reasons" based in policy to permit removal jurisdiction. *Id.* at 2069. Here, this Court's rulings in *Pegram* and other recent cases raise serious questions about whether state medical malpractice claims are preempted by ERISA. Comity concerns dictate that state courts be permitted to address this important question in the first instance, subject to this Court's review.

for ERISA preemption generally. Petitioners and their supporting *amici* conflate the issues.[6] The Fifth Circuit correctly concluded that respondents' claims do not arise under ERISA and thus are not removable under § 502. The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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[6] To cite one more example, we are befuddled by the Justice Department's assertion that the "court of appeals held that respondents' claims are not completely preempted – indeed, are not preempted at all * * * ." *See* U.S. Br. 17. It is simply wrong to suggest that the Fifth Circuit held that respondents' claims "are not preempted at all." After deciding it lacked jurisdiction over Calad and Davila's claims, the court did the only thing it could do: it left the substantive preemption issue for resolution by the Texas courts on remand. With respect to Robert Roark, as noted above, the court felt bound by outdated circuit precedent and reluctantly held that similar state-law claims *are* preempted by § 514. *See* Cigna Pet. App. 24a-28a. The Justice Department's misstatement of the Fifth Circuit's holding, coupled with petitioners' silence regarding the lower court's ruling in their favor on the substantive preemption issue, serve to obscure the critical distinction between removal preemption under § 502 and express preemption.

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IN THE

Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.
and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICUS CURIAE HEALTH ADMINISTRATION RESPONSIBILITY PROJECT IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICUS CURIAE

This brief is respectfully submitted on behalf of amicus curiae Health Administration Responsibility Project.[1] The interests of the amicus curiae is as follows:

Health Administration Responsibility Project (HARP) is a non-profit organization that serves as an educational and informational resource for patients, doctors, and attorneys regarding managed care organizations, and seeks to enhance the quality of medical care benefits provided in the managed care setting. Because these cases implicate a statutory remedy scheme for an HMO's failure to exercise due care in the rendition of medical services similar to that established under California law (Civil Code section 3428), HARP has an immediate interest in assuring that such protections remain viable and enforceable.

SUMMARY OF ARGUMENT

The major, and perhaps the only, real question affecting the implementation of the Texas Health Care Liability Act ("THCLA") (Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003) against the insurer defendants in these cases, is whether Congress intended to deprive employee plan beneficiaries of non-ERISA remedies as against defendants who are not employee plans and who are thus not regulated by ERISA.

The Federal judicial preemption of state remedies for insurance company malfeasance has allowed ERISA to evolve into a shield that insulates insurers doing business with employee plans from liability for even the most egregious derelictions committed against the very plan beneficiaries that ERISA was intended and designed to protect. (*cf*: *DeFelice v. Aetna*, Third Circuit No. 02-3381 (2003), Baxter Concurrence)

---

1. Petitioners and Respondents have filed blanket consents to the submission of amicus briefs with this Court. Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did any person or entity other than Amicus Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

Aetna blatantly exploits this immunity, to the detriment of ERISA enrollees, as shown in their training videotape for claims managers, entered in evidence in a prior case, *Fisher v. Aetna Life Insurance Co.*, No. 3AN97-291, Alaska Super., Anchorage (1998). In that video, the Aetna instructors tell the claims managers that they should just deny ERISA claims without investigation, since there is no liability for bad-faith damages. But with respect to non-ERISA cases, they must be carefully investigated because of the risk of potential bad faith and punitive damages liability. (See: "Aetna video fuels renewed HMO fight" by Laura Meckler, *Associated Press*, October 13, 1998; Tale of Aetna tape: fear of suit a factor in health claim reviews" by Daniel M. Weintraub, *The Orange County Register*, October 25, 1998, News, pg. A 04; "Law Keeps Many Patients From Suing Health Insurers" by Jane Bryant Quinn, *Seattle Post-Intelligencer*, November 24, 1998, Business, pg. C1.) This dichotomy in claims handling exemplifies the need to restrict the application of ERISA preemption to the entities ERISA was designed to regulate – the plans, not contractors to the plans.

The statute at issue in these cases, the THCLA, was specifically designed to impose some measure of control over such injurious practices of insurers – not plans.

As the Fifth Circuit has effectively demonstrated in the opinions being appealed, the THCLA exclusively regulates insurance, and thus falls under the protection of ERISA's saving clause, 29 U.S.C. § 1144. As such, it is not subject to field preemption. Nor does the statute interfere with any of the remedies of ERISA. As such it is not subject to conflict preemption.

Thus the only remaining issue regarding the applicability of THCLA to the insurers in these cases is whether ERISA's equitable remedies were intended to be "exclusive" as against **non-plan** defendants. The letter of ERISA, and its legislative history, demonstrate that they were not.

The best way to satisfy explicit Congressional intent while adhering to the strict language of the law is to define the scope of ERISA as applying to the **insurance coverage** paid for by **the plan**, not **the medical service** paid for **by the insurer**. Only the failure to provide that insurance coverage should be a violation subjecting the plan to the remedies of § 502(a). The insurer's failure to pay for or provide specific medical service should subject the insurer to state contract and tort remedies, since ERISA provides no federal jurisdiction over such non-plan entities.

LEGAL ARGUMENT

1. CONGRESS DID NOT INTEND TO LIMIT THE REMEDIES OF ERISA BENEFICIARIES AGAINST NON-PLAN DEFENDANTS

Where "federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the 'assumption that **the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress**.'" (*New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); emphasis added.)

In ERISA, Congress manifested its purpose to: **"protect . . . participants in employee benefit plans and their beneficiaries"** (29 U.S.C. § 1001(b); emphasis added.)

This Congressional intent was further clarified by Rep. Perkins during the House debate of August 20, 1974 on the final conference report:

> . . . the purpose of this conference report is relatively simple. It is designed to reduce sharply the number of people who pay money into private pension plans year after year expecting eventually to receive retirement income, only to have their hopes dashed and end up getting nothing.

(Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess ("Leg. Hist.") p.4657).

As with so much of ERISA, this comment is directed at the pension aspect rather than the welfare aspect of the bill, but the application to health plans is obvious. The bill was designed to see that beneficiaries get what they're entitled to, not to put obstacles in their path.

Congress nowhere said in the bill, in the conference reports, or in the floor debates, that it intended to protect employers or employee benefit plans for their own sake. It most assuredly did not assert an intention to protect from state tort or contract remedies any third party that happened to do business with a benefit plan. Nor did it assert any intention to lower health care costs by encouraging insurers to deny needed medical care through immunity from liability. That is a recently-appearing political issue with which the courts should not become embroiled.

In fact, the savings clause itself makes clear that ERISA's preemption clause was not intended to protect insurers who sold coverage to employee benefit plans. ERISA's preemption provision, section 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A), explicitly provides that "*nothing in this subchapter* shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance, banking or securities." (Emphasis added.) The subchapter referenced in that subdivision, *includes ERISA's remedies provisions,* i.e., ERISA section 502, 29 U.S.C. § 1132. Congress said it very plainly: *Nothing* in the subchapter – including the remedies provision – can be construed to exempt insurers from state law regulation. That must, therefore, necessarily include state laws regulating the remedies imposed on insurers.

Nor does this do any harm to Congress's intent to provide administrative protection to ERISA plans. As this Court acknowledged in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), there is a distinction – and properly so – between ERISA plans themselves and the insurance protection they buy. Allowing state laws to impose different remedies against *insurance companies* when *insurance companies* violate state insurance law does

nothing to thwart Congress's intent to protect the administrative regulation of the plan itself.

In view of Congress' single-minded purpose of protecting plan beneficiaries, it is unreasonable to infer that it would enact a blanket preemption simply because it wanted to prevent beneficiaries from being fully compensated for their injuries, to the benefit only of unscrupulous third-party tortfeasors. The only consistent rationale for ERISA's preemption provisions is to preserve the assets of the employee benefit plans so they could be used for the benefit of all enrollees. However, a suit against an HMO or insurance company contractor of an insured benefit plan obviously does not threaten the **plan's** assets. The only interpretation compatible with the purposes of ERISA is that if the remedies of § 502 were intended to be the "exclusive remedy", they were intended to be exclusive **only** as against the plan, not the producer of the product sold to the plan. The plan is the only entity regulated by ERISA, and the only one whose assets Congress was anxious to preserve for the benefit of other beneficiaries.

Thus, to be consistent with expressed congressional intent, ERISA should not be interpreted so as to sacrifice the interests of beneficiaries to the competing interests of third-party insurers.

Claims have been made that preemption is necessary to encourage the formation of employee benefit plans. But there has never been any indication of how allowing beneficiaries to recover from unrelated third parties would "discourage" the formation of benefit plans. This argument clearly has no force.

If the beneficiary sues an independent risk-bearing insurer, and if there is any effect on the plan's assets at all, it would be indirect. If the insurer raises its rates because of litigation losses, the plan has the choice of remaining with that insurer, or switching to an insurer which acts reasonably and, as such, doesn't incur those litigation losses. This Court has already stated that such indirect effects do not implicate ERISA preemption. (*Travelers*, 514 U.S. 645, 659) And in *De Buono v. NYSA-ILA Med. and Clinical Servs.*, 520 U.S. 806, 815, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997) this Court went even further, stating

that "myriad state laws" of general applicability that impose even direct burdens on the administration of ERISA plans nevertheless do not necessarily "relate to" them within the meaning of ERISA. "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute." (*Ibid*, p.816)

This Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) explicitly refused to support the proposition that an insurer inherits the protection that an employee benefit plan might be entitled to if it were acting on its own:

> Footnote 4: "Because we conclude that Dedeaux's state common law claims fall under the ERISA pre-emption clause and are not rescued by the saving clause, **we need not reach Pilot's argument that when an insurance company is engaged in the processing and review of claims for benefits under an employee benefit plan, it is acting in place of the plan's trustees and should be protected from direct state regulation by the deemer clause."**

(Emphasis added)

An insurer might make the "agency" argument if it were solely a non-risk-bearing administrator of the benefit plan, and the benefit plan itself was at risk for the damages. But if the benefit plan merely paid insurance premiums, and the insurer was the only party at financial risk, Congress would have had no reason to frustrate ERISA's basic purpose of protecting beneficiaries, or to put them in a far worse legal position than those who do not have the "benefit" of federal "protection".

Rep. Perkins admitted on the House floor that: "On a bill so vastly complicated some consequences are almost certainly unforeseen and some problems will arise . . ." (Leg. Hist. p.4685) This argues against the frequently-expressed view that ERISA

is so "finely crafted" that its words must be taken literally, even when doing so subverts the expressed purpose of the bill.

One of the greatest problems with the bill is that its drafters were focused almost entirely on abuses of **pension** plans, and welfare benefit plans were tacked on almost as an afterthought. This is apparent throughout the floor debates as well as in the bill itself. All of the "horror stories" offered by proponents to support passage of the bill were related to losses of pension benefits. There is no reference to loss of medical benefits in the 5319 pages of legislative history. Thus equitable remedies, which might be entirely satisfactory to a person denied only monetary pension payments, should not be assumed to be intended as the sole remedy for someone who has suffered injury or death due to negligent or intentional denial of needed medical benefits – a remedy that has proven to be entirely inadequate. (*See, e.g.*, *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (1988); *Olson v. General Dynamics* 960 F.2d 1418, ¶27 (9th Cir. 1991), concurring opinion; *Dishman v. Unum*, DC# CV-96-00015-JSL (C.D. CA 1997); *Andrews-Clarke v. Travelers Insur. Co., et al.*, 984 F. Supp. 49, 52 *et seq.* (1997).)

To the extent compatible with the literal meaning of the law, ERISA should be interpreted to protect beneficiaries denied medical care by HMOs, and not to restrict them to remedies appropriate only for denial of pension benefits, or denial of insurance coverage by a plan.

2. SUITS AGAINST HMOS SHOULD BE SUBJECT TO THE PREEMPTION PROVISIONS OF THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973, NOT THOSE OF ERISA

Davila and Calad are suing HMOs, not employee benefit plans. In addition to the fact that ERISA's preemption clause specifically saves from preemption actions against insurers, even as to state remedy schemes, Congress also explicitly delineated the scope of federal preemption for HMOs. The very same Congress that passed ERISA passed the HMO Act of 1973 only a few months before. That Act's very moderate preemption

section (42 U.S.C. § 300e-10) is quoted in full below, explicitly stating the degree of preemption to be applied to state laws affecting HMOs. **This** is the appropriate preemption provision to be applied to suits against HMOs, **not** that in ERISA.

Sec. 300e-10. – Restrictive State laws and practices

(a) Entities operating as health maintenance organizations

In the case of any entity –

(1) which **cannot do business as a health maintenance organization** in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise –

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or

(E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, **and**

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees'

health benefits plans), **such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.**

(b) Advertising

No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgement concerning, any health professional who provides services for a health maintenance organization.

(c) Digest of State laws, regulations, and practices; legal consultative assistance

The Secretary shall, within 6 months after October 8, 1976, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least annually and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section.

With the passage of this very moderate preemption clause fresh in their minds, it is inconceivable that those who passed it would intend to override it the very next year of the same congressional session, without expressly saying so.

3. LEGISLATIVE HISTORY DEMONSTRATES THAT THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973 WAS ALSO THE MODEL FOR ERISA PREEMPTION

Even if the preemption provisions of ERISA **are** determined to apply to HMOs when they do business with employee benefit plans, those ERISA provisions should be interpreted in the light of the relatively moderate HMO Act of 1973.

This Court stated in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983):

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language.
>
> See H.R. Conf. Rep. No. 93-1280, p.383 (1974); S. Conf. Rep. No. 93-1090, p.383 (1974).

However, that Conference Committee Report actually gave no explanation whatever for the change from the language of the bills passed by both houses, nor any suggestion that the omission was even intentional. It made no reference at all to the prior versions. All it did was restate the final statutory language in a more conversational format. It is not at all clear that a substantive change was intended. (Leg. Hist. p.4650)

Representative Dent, the House sponsor of the bill, in an oft-quoted oratorical flourish, described the "reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans" as "what to many is the crowning achievement." of ERISA. 120 Congr. Rec. 29197 (1974).

However, he then went on to say:

> **. . . we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation**. [n.b.: conflict preemption, not complete preemption]. **We followed to a large extent the same approach as in Public Law 93-222, 87 statute (414) where the regulation of health maintenance organizations was foreclosed to State authority-section 113(a).**

(Emphasis added) (Leg. Hist. p.4670)

So we can discern how the ERISA Congress intended preemption to protect participants, by looking at the preemption section of the HMO Act of 1973 (P.L. 93-222) that Rep. Dent referred to, which is codified, unamended, at 42 U.S.C. § 300e-10, and reproduced in full above. This section, **the declared model for ERISA preemption**, is seen to mandate only a very limited form of conflict preemption.

The contrast between the extremely cautious and narrowly-targeted preemption provisions of the HMO Act, affecting **only** state laws which might prevent an HMO from doing business, and the oppressively ruthless preemption of ERISA as currently applied, for which the former served as a model, is dramatic. It is clear that the current scorched-earth interpretation of preemption is far from the intentions of the drafters.

Senator Williams, the Senate sponsor of the bill, said:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus **eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans**. This principle is intended to apply in its broadest sense to all actions of State or local governments, or

> any instrumentality thereof, which have the force or effect of law.

(Leg. Hist. 4745-46)

He too, though using the term "field", demonstrates that he really intended "conflict preemption".

The last sentence in the above quote is clearly not designed to preempt all State tort and contract law, but to eliminate **only conflicting regulation** by any instrumentality of State or local government, e.g. Medical Boards and Bar Associations, as the subsequent comments of Sen. Javits with respect to legal service plans make clear:

> Section 514 of the act does not preempt State bar associations from adopting and enforcing ethical rules or guidelines generally and/or from disciplining its members . . . But the State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan . . . in the guise of disciplinary or ethical rules or proceedings.

(Leg. Hist. p.4789)

The ERISA drafters speak only about State **regulation of employee benefit plans**, never about non-plan entities, and in particular, never about tort or contract law as applied to non-plan entities by beneficiaries. The expansiveness of the language above refers to all possible regulators of plans, not all possible laws, and not all possible defendants.

Sen. Javits also appeared to intend that the bill mandated only **conflict** preemption: "In view of Federal preemption, **State laws compelling disclosure . . . , imposing fiduciary requirements . . . , imposing criminal penalties on failure to contribute . . . , establishing State termination insurance programs, etc., will be superseded**." (Leg. Hist p.4771) (Emphasis added.)

We thus see the kinds of laws that Congress intended to preempt. There is nothing about protecting individual or

corporate tortfeasors employed by or contracting with an employee benefit plan. By the principle of *ejusdem generis*, it should be concluded that preemption was intended to apply only to state regulations of the sort specified by Sen. Javits, Sen. Williams, and Rep. Dent .

4. LEGISLATIVE HISTORY DEMONSTRATES THAT THE MODEL FOR ERISA PREEMPTION WAS NOT THE LABOR MANAGEMENT RELATION ACT

What then is to be made of the claim, asserted throughout *Pilot Life*, 481 U.S. 41, 52 *et seq.*, that ERISA preemption was based on the severe preemption provisions of § 301 of the Labor-Management Relations Act of 1947? Respectfully, that is not an accurate assertion, based on ERISA's legislative history.

The Conference Report on ERISA describing the civil enforcement provisions of § 502(a) says:

> . . . With respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the Title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. **All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947**.

H.R. Conf. Rep. No. 93-1280, p.327 (1974) (emphasis added). (Leg. Hist. p.4593, last paragraph)

This section says **nothing** about preemption. It refers to the LMRA **only** to exemplify the combined Federal-State jurisdiction over federal civil claims. Indeed, the conference report never mentioned the preemptive force of § 301, and referred to it only for this jurisdictional analogy.

The **only** federal law ever referred to anywhere in the legislative history as a model for the **preemption** portion of

ERISA, is the HMO Act of 1973, passed by this same Congress, and which imposes a very **weak** conflict preemption.

> On numerous occasions we have noted that "in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy."

(*Pilot Life v Dedeaux*, 481 U.S. 41, 51 (1987), quoting ultimately *United States v. Heirs of Boisdore*, 8 How. 113, 122 (1849).)

And the "object and policy" of ERISA is to increase the protection of workers against the schemes of predatory employers and insurers. How does stripping them of rights, which don't deplete the plan's fund, achieve that end? Shall that essential purpose of ERISA be frustrated and even turned on its head by a misunderstanding of a single comment made in a conference report?

5. STATE LAWS AFFECTING ONLY INSURERS AND NOT EMPLOYEE BENEFIT PLANS DO NOT NEED TO BE SAVED BY § 514(b)(2)(A) SINCE THEY DO NOT 'RELATE TO' AN EMPLOYEE BENEFIT PLAN WITHIN THE MEANING OF ERISA IN THE FIRST PLACE

In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), a Massachusetts statute required certain mental health care benefits in general health insurance policies. The Court concluded, first, (p.739) that the Massachusetts statute did "relate to . . . employee benefit plan[s]," thus placing the state statute within the broad sweep of the pre-emption clause, § 514(a). However, the Court then held that, because the state statute was one that "regulate[d] insurance," the saving clause prevented the state law from being pre-empted. (guided by the McCarran-Ferguson Act).

Though the result is surely correct, the reasoning cannot be. If an employee benefit plan or its insurer hired a doctor, and the State required that the doctor be licensed by a medical board,

the logic of *Metropolitan Life* would say that this "relates to" the employee benefit plan for the same reason that regulation of an insurer which contracts with an employee benefit plan "relates to" such plans. But a doctor licensure law will not be saved under the insurance saving clause, since it does not regulate insurance, so, by the logic of *Metropolitan Life* it would have to be concluded that medical licensure laws are preempted and employee benefit plans and their contracting HMOs are free to hire non-licensed persons to give medical care. But this is absurd, and surely not what Congress or this Court would intend. So the major premise, that State regulation of non-plan entities which contract with plans automatically "relates to" employee benefit plans, must be rejected.

Similarly, *Pilot Life* stated in dictum: "There is no dispute that the common law causes of action asserted in Dedeaux's complaint [against an insurer of an employee benefit plan] "relate to" an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a)." (481 U.S. at 47).

But there **is** a dispute on that issue. That defendant was not an employee benefit plan, and any payment by the independent insurer would have no effect on the assets of the plan, so that could not have been the sort of claim Congress intended to preempt.

This Court recognized and corrected these errors in *De Buono*, as noted above, so that state tort and contract laws affecting all insurance plans, must be some of the "myriad state laws" of general applicability that may impose some burdens on the administration of ERISA plans, but nevertheless do not "relate to" them within the meaning of ERISA

And even the *Metropolitan Life* Court, 471 U.S. at 746, rejected an interpretation of the saving clause that saved from pre-emption "only state regulations unrelated to the substantive provisions of ERISA." Or, rephrased: "There may be some State insurance regulations which will be valid even if they relate to substantive provisions of ERISA."

So which are those provisions that are not preempted? They can only be those which apply to all insurers, and do not **conflict** with the substantive provisions of ERISA – for instance, additional remedies against non-plan, non-trustee defendants. There can be no conflict there, since ERISA has nothing to say about remedies against non-plan, non-trustee defendants.

Thus State laws affecting only insurers – and not plans – do not need to be saved by the 'savings' clause, since they do not 'relate to' a plan within the meaning of ERISA in the first instance.

6. INDIVIDUAL MEDICAL PROCEDURES ARE NOT BENEFITS OF AN INSURED BENEFIT PLAN, SO DENIAL SHOULD NOT BE LIMITED TO § 502 REMEDIES

ERISA comprehensively regulates, among other things, employee welfare benefit **plans** that, "through the purchase of insurance or otherwise," provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U.S.C. § 1002(1).

Thus, ERISA regulates **plans**, **not** insurers.

An insured plan has no clauses guaranteeing access to Vioxx, or specifying lengths of hospital stay, benefits at issue in the cases of Davila and Calad. Those are not benefits of the plan. Access to **individual medical procedures** are benefits of the insurance contract, subject to a plethora of conditions precedent specified within that contract, and traditionally interpreted according to State laws, none of which is within the control or expertise of the plan managers.

This source of frequent confusion and litigation would be greatly clarified if this Court simply declared definitively that when an employee benefit plan provides benefits by purchasing insurance, **it is only the insurance coverage itself which is the benefit of the plan**, the denial of which will subject the plan to the civil enforcement provisions of § 502. If the risk-bearing insurer subsequently denies particular benefits promised

under **the insurance policy**, the insurer is subject to State law in the same manner as it would be if it sold the same policy to a non-plan customer.

This is completely analogous to this Court's view of medical malpractice by a doctor referred to by a self-insured plan. The **referral** to the doctor is the benefit of the plan, subject to § 502. If the doctor fails to properly perform the procedure, he is subject to State negligence law in the same manner as he or any other doctor would be if the patient were not covered by ERISA. "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." (*Pegram v. Herdrich*, 530 U.S. 211, 237 (2000)) And there has been no such manifestation.

This interpretation is most consistent with ERISA's dual intent of maximizing the ability of plan enrollees to enforce their rights, and not putting plan assets at excessive risk.

Since ERISA does not regulate insurance contracts, the Insurer's breach of the insurance contract should not be subject to the limitations of ERISA. Insurers are traditionally, and under ERISA, subject only to state laws and regulations and to the federal HMO Act, which has its own, quite mild, preemption provisions. Large bodies of State law have arisen expressly to deal with such insurance disputes, whereas the primary federal "remedy" appears to be F.R.C.P. 12(b)(6).

7. PLEAS FROM THE FEDERAL BENCH FOR REINTERPRETATION OF ERISA JURISPRUDENCE

Many Federal judges have railed against the injustices perpetrated on plan beneficiaries by the current interpretation of ERISA, and have urged that the rules be revised, even as they reluctantly enforced them. We agree with their views, except where they believe that this situation was the intent of Congress and only Congress can solve it. For the reasons raised above, the current situation is the antithesis of the Congressional intent,

and that it is well within the power of this Court to remedy the deplorable state into which employee welfare benefit plans have fallen.

Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822, 827 (1988):

> If the congressional intention were to immunize insurance companies from liability whenever they can show some arguable reason for their refusal to pay a claim, federal district courts should have already ordered the appropriate rubber stamps. If this court is looking in the mouth of the gift horse that would allow the court to abdicate is routine responsibility, it is because there are countervailing forces called "justice" and the Seventh Amendment's guarantee of a jury trial, both of where here give this court pause. There is [a] growing phalanx of courts expressing the fear that ERISA will continue to expand and to preempt everything in its meandering path.

Olson v. General Dynamics, 960 F.2d 1418, ¶27 (9th Cir. 1991), concurrence:

> I agree that ERISA preempts appellant's state law fraud claim, and that no federal or other remedy now exists for the wrongful conduct he alleges. Even if the defendants defrauded Olson . . . Olson may not assert the state cause of action he would have been entitled to plead prior to the enactment of ERISA. Because of the passage of ERISA, Olson is left without a remedy.
>
> Unfortunately, his fate is not unique. Congress enacted ERISA in 1974 in order to protect the rights of participants in private pension plans to a stable, secure source of retirement income. . . . [H]owever, **a statute designed to safeguard employee retirement benefits has, all to frequently, been used to deprive employees of rights they previously enjoyed** under state law while failing to provide any comparable

> federal remedy. The federal courts have routinely found state tort and implied contract remedies preempted by section 514(a) even when ERISA provides no substitute for the state cause of action.
>
> . . .
>
> The proliferation of ERISA preemption cases, in my view, raises a question as to whether **ERISA is having an effect that is substantially contrary to that intended** by those who favored its adoption.

Corcoran v. United Healthcare, 965 F.2d 1321, ¶¶65-67 (5th Cir. 1992):

> The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons.
>
> First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is **theoretically less deterrence of substandard medical decisionmaking**. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, **bad medical judgments will end up being cost-free** to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.
>
> Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a

prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

Finally, **cost containment features such as the one at issue in this case did not exist when Congress passed ERISA**. . . . Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees.

Cannon v. Group Health 77 F.3d 1270, ¶1 (10th Cir. 1996):

Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm.

Dishman v. Unum, DC# CV-96-00015-JSL (C.D. CA 1997):

This case reveals that for benefit plans funded and administered by insurance companies, **there is no practical or legal deterrent to unscrupulous claims practices.** Without these practical incentives, there is no counter-balance to insurance companies' interest in minimizing ERISA claims . . . The fact that most people in Dishmans' situation would have had to capitulate is the most troubling aspect of this case. The need to deter insurance companies from behaving in this manner is why 'bad faith' liability exists under almost all state laws. ERISA preempts such laws. Under ERISA, no matter how unfounded the denial

of a claim may be, the only recover permitted to the claimant is the amount of the benefit. . . .

UNUM's **unscrupulous conduct** in this action **may be closer to the norm of insurance company practice than the Court has previously suspected**. . . . Absent . . . deterrents [to these unscrupulous claims practices], the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

Andrews-Clarke v. Travelers Insur. Co., et al., 984 F. Supp. 49, 52 *et seq.* (1997):

[Defendants] promptly removed her case to this Court and then, just as promptly, asked this Court to throw her out without hearing the merits of her claim. This, of course, is ridiculous. The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. . . .

Under the traditional notions of justice, the harms alleged – if true – should [mandate] some legal remedy . . . Consider just one of her claims – breach of contract. This cause of action – that contractual promises can be enforced in the courts – pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it. . . . [N]evertheless this court had no choice but to pluck [the] case out of state court in which she [his wife] sought redress and then, at the behest of Travelers, to slam the courthouse doors in her face and leave her without any remedy.

. . .

> Although the alleged conduct of [defendants] in this case in extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a **statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent**. Does anyone care? Do you?

DeFelice v. Aetna, Third Circuit No. 02-3381 (10/15/2003), concurring opinion by Becker:

> I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is **an unjust and increasingly tangled ERISA regime**. Congress enacted ERISA in 1974 "to promote the interest of employees and their beneficiaries in employee benefit plans.". . . .
>
> However, with the rise of managed care and the Supreme Court's series of decisions holding preempted any action for damages against HMOs, **ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries**, a state of affairs that I view as directly contrary to the intent of Congress.
>
> Indeed, existing **ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries**, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess. Lower courts have struggled to maintain some semblance of equity notwithstanding the enormous breadth of the preemption test, one that turns on whether the claim is "related to" a benefit plan, *inter alia,* by identifying exceptions to § 514 preemption, such as that for medical malpractice liability. And in terms of the remedial scope of § 502,

> they have struggled to make sense out of the distinction between eligibility decisions (which are preempted) and medical decisions (which are not), a hopeless endeavor, as I shall explain.

Unfortunately, the price of all this has been descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases.

The underlying goal, purpose and intent of Congress in enacting ERISA has been undermind and misdirected with regard to insurer regulation. It is time to take a step back and reassess ERISA's language and structure in light of the statute's purpose. That reassessment must irrevocably result in the conclusion that state tort remedies against insurers who sell coverage to an ERISA plan are not preempted.

CONCLUSION

For the above reasons, amicus urges the Court to find that:

1. The ERISA benefit of an insured welfare benefit plan is the insurance coverage paid for by the plan, not the medical service paid for by the insurer under the insurance contract.

2. Only the plan's failure to provide the insurance coverage itself should be the violation which subjects the plan to the remedies of § 502(a).

3. The insurer's failure to pay for or provide specific medical service under the insurance contract subjects the insurer, but not the ERISA plan, to state contract and tort remedies.

4. Since the THCLA affects only insurers and not ERISA plans, it is not preempted by ERISA.

Respectfully submitted,

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AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, *et al.*,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICUS CURIAE*

United Policyholders is a national, not-for-profit educational organization whose mission is to educate the public, legislators and the courts on insurance issues and consumer rights, and to assist policyholders in securing prompt and fair insurance settlements.[1] The resolution of the issue presented in this case is of great importance to United Policyholders and its members because of its potential application to a wide range of laws affecting employees insured through an ERISA plan.

SUMMARY OF ARGUMENT

In *Difelice v. Aetna U.S. Healthcare,* 346 F.3d 442, 453 (3rd Cir. 2003), Justice Becker writes in concurrence, "I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime." *Id.* at 453. We submit that the root of the innumerable difficulties that have plagued the Courts is language from this Court's decision in *Pilot Life v. Dedeux,* 481 U.S. 41 (1987). Petitioners have urged this Court to extend that dicta and apply it to the circumstances here. We urge the Court to resist such an extension of *Pilot Life,* which we posit cannot withstand either scrutiny or logic in light of all that has transpired since its issuance. Indeed, *Pilot Life's* dicta has required federal courts to "struggle mightily to maintain fidelity to ERISA's expansive"[2]

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[1] United Policyholders, as *amicus curiae*, has obtained the consent of both the Petitioner and the Respondents to submit this brief. The letters of consent have been lodged with the Clerk of the Court. No counsel for any party in this case authored this brief in whole or in part, and no person or entity other than United Policyholders and its members made any monetary contribution to the preparation or submission of this brief.

[2] *Difelice* 346 F.3d at 54 (Becker, J., concurring.)

preemption while continuing to respect the rights of states to regulate insurance.

This Court has courageously remarked on prior occasions that its initial take on ERISA preemption has not always been accurate and has stepped forward to correct itself on more than one occasion. *See Kentucky Association of Health Plans, Inc. v. Miller,* 538 U.S. 329, 123 S.Ct. 1471 (2003) (making a clean break from past criteria used to determine whether a law regulates insurance within scope of saving clause); *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.*, 519 U.S. 316, 335 (1997) (ERISA preemption criteria set forth in some of the court's earlier cases, including *Pilot Life,* have "in effect been abandoned" as "a project doomed to failure" (Scalia, J., concurring); *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.,* 514 U.S. 645, 655 (1995) (recognizing that prior attempts at construing the phrase "relate to" in preemption clause "does not give us much help . . .").

United States Senior District Judge Newcomer has recently found *Pilot Life's* reasoning "unpersuasive" and "flawed" in important respects. *Rosenbaum v. Unum Life Ins. Co. of America*, 2003 WL 22078557 (E.D. Pa.). *See also Stone v. Disability Management Services, Inc.,* 288 F. Supp.2d 684, 695-96 (2003) (noting "persuasive" reasoning of *Rosenbaum*). As Justice Becker proposes, the inequities inherent in ERISA, as interpreted thus far by the courts, "cry out for clarification by Congress or, failing that, by the Supreme Court. . . . The time might be right [for the Supreme Court] to reconsider its prior rulings." *Id.* at 461, 465. And Justice Calabresi in *Cicio v. Does,* 321 F.3d 83, 106 (2d Cir. 2003), writes, " . . . the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end." (Calabresi, J. dissenting in part.)

In *Pilot Life*, this Court held that ERISA preempted a state law claim for tortious breach of contract arising from an insured ERISA disability benefits plan. The Court

found that the state law claim related to ERISA and was not saved from preemption because the Mississippi law was not aimed specifically at the insurance industry.[3] As part of the Court's analysis of the saving clause issue in *Pilot Life*, and in accordance with the views of the Solicitor General, it relied upon the structure and legislative history of the civil enforcement provisions contained in ERISA Section 502 to bolster its conclusion that Congress intended ERISA to preempt the state law remedy at issue in that action. *Pilot Life*, 481 U.S. at 51-52.

This Court has recently pointed out that *Pilot Life* does not resolve Section 502's impact on laws encompassed by the saving clause. *See Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 377 (2002) ("we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the 'reservation of the business of insurance to the States,'"); *UNUM Life Insurance Co. of Am. v. Ward*, 526 U.S. 358, 377 n.7 (1999) ("[This] case does not raise the question whether § 1132(a) provides the sole launching ground for an ERISA enforcement action"; *Pilot Life's* holding was "in the context" of a law which was not saved from preemption). Further, in *Franchise Tax Board of California v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 25 (1983), this Court clearly held that "[the saving clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to" ERISA plans. In addition, the Solicitor General has specifically pointed out that the Section 502 implied preemption analysis it presented in *Pilot Life* would not apply in a case where the state law remedy at issue was a state law regulating insurance. *Ward*, 526 U.S. 358, 377 n.7. Moreover, the

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[3] This holding in *Pilot Life* was substantially modified in *Kentucky Association of Health Plans, Inc. v. Miller,* 538 U.S. 329, 123 S.Ct. 1471, 1478-79 (2003) in which this Court made a clean break from the criteria used in *Pilot Life,* to determine whether a law regulated insurance within the meaning of the saving clause.

limited application of *Pilot Life's* Section 502 implied preemption analysis is reflected in the Court's final sentence: " . . . [W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by [the saving clause] *and therefore* is pre-empted by [the preemption clause]." *Pilot Life*, 481 U.S. at 57 (emphasis added).

In *Pilot Life* the Court notes that the remedial provision of ERISA was intended to represent the exclusive remedies available to an ERISA plan participant and thus, the state law at issue was preempted to the extent it provided a remedy not authorized under ERISA. *Pilot Life,* 481 U.S. at 54. Petitioners urge the Court to extend that reasoning to apply even if the law at issue is saved from preemption. Critically, however, the reasoning this Court used in *Pilot Life* only applies to laws of general application and does not logically extend to laws that fall within the saving clause. ERISA's clear purpose, when enacted, was to regulate pension and not insurance difficulties and the statute is clear on its face that the saving clause is not affected by Section 502. In addition, the remedies provided under ERISA are not suited to insurance disputes and there is nothing in the legislative history of ERISA which would constitute a clear and manifest intent of Congress that the saving clause be subservient to Section 502. Eminent jurists and commentators have also concluded that an extension of *Pilot Life*, as advocated by Petitioners here, strains all logic in both the interpretation of ERISA as well as its practical application. They urge this Court, as we do, to limit the effect of *Pilot Life*.

ARGUMENT

I. *All* Laws Which Regulate Insurance Are Saved From Preemption Pursuant To The Clear And Unambiguous Text Of ERISA.

ERISA was enacted as a pension reform bill intended to protect the retirement benefits of workers. *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001(b). Protecting "the continued well-being and

security of millions of employees and their dependents" was an express Congressional declaration of policy. 29 U.S.C. § 1001. ERISA comprehensively regulates pension plans. Importantly, ERISA does not comprehensively regulate the terms of non-pension employee benefit plans.[4]

In addition to its substantive provisions, ERISA includes a preemption clause, which provides that, "except as provided in [the saving clause, ERISA] . . . shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan. . . ." ERISA § 514(a), 29 U.S.C. § 1144(a). This Court has described the preemption clause as "expansive."[5] However, the preemption clause is modified by the saving clause, which declares " . . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This saving clause is "phrased with similar breadth"[6] as the preemption clause.[7]

A remedial provision is found in the same subchapter as the preemption and saving clauses. ERISA Section 502, 29 U.S.C. § 1102, contains a set of remedies available under ERISA to plan participants. Thus, on the face of the statute, all remedies available under ERISA would constitute the exclusive remedies, unless a state remedial law was saved from preemption. In that event, "*nothing* in this

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[4] *See* Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 951 (2000) (hereafter, Bogan, *Protecting Patient Rights*).

[5] *See New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 655 (1995); *Pilot Life,* 481 U.S. at 46.

[6] *Unum Life Ins. Co. of America v. Ward,* 526 U.S. 358, 363 (1999).

[7] *Ward,* 526 U.S. at 363 ("[P]re-emption is substantially qualified by an 'insurance saving clause,' . . . which broadly [saves state insurance laws]. . . . "); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 740-741 (1985) (" . . . [W]hile the general pre-emption clause broadly preempts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation").

subchapter," which by definition includes Section 502's remedial provisions "*shall* [preempt] . . . *any* . . . State [law which] regulates insurance." (Emphasis added.) Accordingly, any state law that regulates insurance, regardless of whether it creates a remedy or not is saved from preemption.

Issues of statutory construction turn on Congress' intent.[8] The Court must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."[9] Further, the Court must also presume that Congress did not intend to preempt areas of traditional State regulation.[10]

Not only is insurance an area of traditional State regulation, but Congress has specifically designated insurance as a special area of State regulation to be zealously protected from federal regulation. The McCarran-Ferguson Act provides that federal laws shall not be interpreted to supersede state laws regulating the business of insurance. 15 U.S.C. § 1012(b); *Humana, Inc. v. Forsyth,* 525 U.S. 299, 306 (1999). "Congress' 'primary concern' in enacting McCarran-Ferguson was to ensure the States' continued ability to regulate the business of insurance." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). And the ERISA saving clause was designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. *Id.; Ward,* 526

[8] *See Travelers*, 514 U.S. at 655.

[9] *FMC Corp. v. Holliday*, 498 U.S. 52, 57 (1990), *citing Park'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985).

[10] *See Travelers*, 514 U.S. at 655. ("We have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases . . . where federal law is said to bar state action in fields of traditional state regulation, we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress' ") (citations omitted).

U.S. at 375 n.5. Moreover, "[t]here is no discussion in [the legislative] history [of ERISA] of the relationship between the general pre-emption clause and the saving clause, and indeed very little discussion of the saving clause at all." *Metropolitan Life*, 471 U.S. at 745. This Court therefore "decline[d] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself . . . If a state law 'regulates insurance,' . . . it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause. . . ." *Id.* at 746-47.

Given the unambiguous language of the saving clause and the strong prohibitions against preemption of state insurance laws, the conclusion that a state law that falls within the saving clause is still preempted would require a clear and manifest expression of Congressional intent. Yet, as extensively discussed below, there is nothing in either the statute or the legislative history of ERISA even to suggest such an intent, let alone a clear and manifest intention.

II. A Claim That *Pilot Life's* Exclusive Remedy Analysis Should Be Extended To Laws Which Are Saved From Preemption Is Deeply Flawed.

A. The Structure Of ERISA, Including Section 502, Establishes That Congress Did Not Intend To Preempt State Remedial Laws That Are Saved From Preemption.

In *Pilot Life*, this Court stated that Congress intended that all claims arising from an ERISA-governed employee benefit plan which fall within the ambit of ERISA Section 502 must be pursued exclusively through ERISA.[11] This Court founded its conclusion on two factors: (1) the structure of ERISA itself and (2) ERISA's legislative history and, in

[11] *Pilot Life*, 481 U.S. 41.

particular, reference in that history to the preemptive scope of Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 185. Regarding the structure of ERISA, the Court held that the ERISA remedies represented a comprehensive enforcement scheme, which, in light of ERISA's broad preemption clause, was intended to be exclusive. The Court determined that parties were not "free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life,* 481 U.S. at 54.

It is certainly true that Section 502 contains a comprehensive enforcement scheme. However, the saving clause is a fundamental element of that comprehensive scheme. One cannot merely presume that, because Section 502 is comprehensive, that it was intended to prevail over the saving clause in the event of a conflict. Surely Congress was aware that, in order to accomplish such a result, it only need have included in the saving clause language providing that all such laws were saved "except laws providing remedies other than those set forth in Section 502." Or it could simply have prefaced the saving clause with, "except as provided in Section 502." Or it could have invoked a multitude of other ways to make itself clear. Indeed, if there was such a clear and manifest intent of Congress to have Section 502 trump Section 514, it is hard to fathom why Congress did not include such an easy clause in the language of the statute itself.

We must also ask ourselves the question, "If we presume that Congress intended to save from preemption all laws regulating insurance – even laws providing additional remedies – could Congress have expressed its intent more clearly than it did in the statute itself?" The short answer is that it would be hard to imagine language that was more explicit. The statute itself provides that the saving clause supersedes both the preemption clause and the remedial provisions in the event of a conflict.

While the Court's conclusion in *Pilot Life* can be applied to generally applicable state law remedies, or more importantly, to laws affecting pension benefits, the same is not true of laws which fall within the specific Congressionally-carved

exception, which saves laws regulating insurance. Congress did not "reject" remedies specifically provided for within the confines of the saving clause. On the contrary, such laws were specifically saved, not rejected. Further, the saving clause is fundamental to the structure of the Act. It provides that " . . . *nothing* in this subchapter shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Not only are the remedies contained in the same subchapter as the saving clause (remedies in 29 U.S.C. § 1132 saving clause in 29 U.S.C. § 1144), but the saving clause is in the very same statute as the preemption clause (29 U.S.C. § 1144).

The Solicitor General, upon whom this Court relied in *Pilot Life,* has also questioned this Court's suggestion in *Pilot Life* that ERISA Section 502 was intended to be exclusive of all state law remedies. In his amicus brief to the Court in *Ward*, he suggested that this Court should reconsider this part of the *Pilot life* opinion. Br. of United States as *Amicus Curiae* in *Ward*, No. 97-1868 (November 1998) at 7, 20-25.

> We recognize that *Pilot Life* has been read to preclude even state law causes of action arising under laws that "regulate[ ] insurance." That portion of *Pilot Life's* rationale is, however, in significant tension with the text of the insurance savings provision and was unnecessary to *Pilot Life* 's holding that the law at issue there was not in any event an insurance regulation within the meaning of that provision.
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> We do not question [the exclusive remedy] reasoning in *Pilot Life* as a general matter. Unquestionably, "Congress intended § 502(a) to be the exclusive remedy for rights guaranteed under ERISA." [Citations omitted.] And it is certainly true that, outside the context of state laws that "regulate insurance" within the meaning of the ERISA insurance savings clause, that exclusivity of the Section 502 civil enforcement provisions

also appropriately informs the Court's understanding of the scope of ERISA preemption where a plaintiff brings a cause of action under state law that "relates to" an ERISA plan. [Citation omitted.] Congress, in short, clearly intended the remedial provisions of ERISA to be exclusive of any generally applicable state-law remedies related to ERISA plans. [Citations omitted.]

It does not follow, however, that ERISA Section 502 should inform the preemption inquiry to the same extent with respect to a state-law cause of action or remedy that specifically "regulates insurance" as it does with respect to one of general applicability. In that situation, Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanctions to enforce that substantive law, *see, e.g., Metropolitan Life*, 471 U.S. at 734 (suit by state Attorney General against insurer of ERISA plans to enforce provision of state insurance law), especially where the causes of action provided under Section 502 itself are not suited to that purpose.

The savings clause states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). "[T]his subchapter" includes Section 502, which has been construed to provide exclusive remedies under ERISA, as well as the preemption provision itself, Section 514(a). Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be "construed" to relieve or exempt any person from "any law" of a State that regulates insurance. Thus, the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state-mandated benefits laws and other prescriptive measures that do so.

This Court gave effect to the facially unrestricted scope of the insurance savings clause in *Metropolitan Life*, when it "declin[ed] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it," and concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected an interpretation of the [insurance] saving clause . . . that saved from preemption 'only state regulations unrelated to the substantive provisions of ERISA' "). In addition, the force of the savings provision's express terms is reinforced by the Court's frequent recognition – particularly in recent cases – that ERISA's preemption provisions must be read against the background of the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." [Citations omitted.]

Ward Br. at 20, 22-25 (footnotes omitted).

As the Solicitor General has carefully explained, the structure of ERISA and, in particular, Section 502 cannot serve as the clear and manifest intent of Congress required to override the clear terms of the saving clause itself. Moreover, a further look into the structure of the remedial provisions discloses powerful evidence that Congress did *not* intend the remedial provisions to prevail over the saving clause.

To the extent ERISA is implicated, the disputes here – and in nearly all the matters impacted by *Pilot Life* – are, at bottom, insurance disputes between insureds and his/her insurance company (or HMO). Logic would dictate that such disputes be resolved in a lawsuit between an insured on the one hand and the insurer or HMO on the other hand. However, ERISA's remedial provision is not set up that way. There is a third party, which is inexplicably inserted into the middle of the dispute. This is the

ERISA plan itself. ERISA requires that an action to recover benefits must be brought against the plan as an entity. "Any money judgment ... against an employee benefit plan shall be enforceable *only against the plan* as an entity and shall not be enforceable against any other person. . . ." 29 U.S.C § 1132(d)(2) (emphasis added). Thus, ERISA does not permit a suit against the insurer, which owes the benefits. "ERISA permits suits to recover benefits only against the Plan as an entity." *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985); *Garratt v. Knowles*, 245 F.3d 941, 949 (7th Cir. 2001). Because of this, courts have repeatedly held insurers are not proper parties to an action under ERISA and have repeatedly dismissed actions filed against insurers.[12]

In the context of a welfare benefit plan in which the only benefit is the purchase of insurance, such a procedures makes no sense in a dispute between an insured and an insurer. A suit against the plan is, at best, a very odd procedure. The plan is not really an entity at all. It is a creation of ERISA and may exist without any documentation, any employees, any office or any funds.[13] Indeed, it can be created as a matter of law without the expressed intention or documentation of anyone.[14] Why would Congress insist that an action for insurance benefits must be

[12] *See, e.g., Everhart v. Allmerica Financial Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 958 (2002); *Gibson v. Prudential Ins. Co. of N. Am.*, 915 F.2d 414, 417 (9th Cir. 1990); *Roeder v. Chemrex, Inc.*, 863 F. Supp. 817, 828 (E.D. Wis. 1994); *Cohen v. Equitable Life Ass. Soc. of the United States*, 196 Cal.App.3d 669, 672-73 (1987).

[13] *See, e.g., Gaylor v. John Hancock Mutual Life Ins. Co.*, 112 F.3d 460, 463-65 (10th Cir. 1997) (ERISA plan determined from surrounding circumstances); *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207, 1213-15 (11th Cir. 1999) (same); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (written plan not necessary to establish ERISA plan); *Marshall v. Bankers Life & Cas. Co.*, 2 Cal. 4th 1045, 1054, 832 P.2d 573 (1992) (same).

[14] *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984).

filed against an entity, which exists in name only, but, in reality, has no assets or personnel? Indeed, in these circumstances, all of the claims decisions are delegated by contract to the insurance company and thus an action by the claimant against the insurer is the obvious manner of resolving such disputes. State courts have been resolving exactly that kind of insurance claim for over 200 years. The "plan" really has no role whatsoever in resolution of the dispute. Yet, under ERISA's structure, in order to obtain benefits, an insured must proceed against the plan and, presumably, if a judgment is entered against the plan, force a second action by the plan against the insurer to obtain the amount of the judgment from the insurer. This is a highly cumbersome and illogical method of obtaining insurance benefits. It is hard to imagine why Congress would impose such a burdensome procedure on a claim that is between an insured and an insurer.[15]

An action solely against the plan does make sense in the case of pension plans and self-funded plans, which are not subject to ERISA's saving clause. These plans are subject to ERISA's substantive provisions regarding vesting and financing. An action directly against such plans makes sense because those plans actually have funds and personnel administering those funds. Thus, ERISA's requirement that a monetary award can only be satisfied

[15] Some courts have held, without statutory authority, that the administrator who controls the plan may be sued. *See, e.g., Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997); *Rosen v. TRW, Inc.*, 979 F.2d 191, 193 (11th Cir. 1992). While insurers are not generally administrators as defined by ERISA (29 U.S.C. § 1002(16)(A)(i)) some courts have still suggested that an insurer may be sued if the claimant can establish that the insurer was the administrator. *See Moran*, 536 U.S. at 363, n.3; *Everhart v. Allmerica Financial Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 958 (2002). Nonetheless, it is highly improbable that the drafters of ERISA would have left an insured's right to sue an insurer dependent on the question of whether the insurer functioned as an administrator – an issue the appellate courts still have not resolved or clarified nearly 30 years after ERISA was enacted.

against the plan, thereby immunizing the administrators from personal liability, makes perfect sense. However, ERISA provides no substantive protections for welfare plans. It, therefore, made sense for Congress to permit these substantive protections to be enforced in state actions directly against insurers through the saving clause. It would make little sense for Congress to have intended that insureds jump through the complicated hoops designed to apply effectively to funded plans, but not designed to work in connection with unfunded plans. Similarly, there is no reason for Congress to have left substantive regulations to the states, but preempted the states' procedures to enforce those rights.

Further evidence of this is found in this Court's jurisprudence. ERISA was intended to "safeguard employees from the abuse and mismanagement of *funds* that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash,* 490 U.S. 107, 113 (1989) (emphasis added). Congress was concerned with the need of *employers* to be able to rely on uniform laws, rather than individual state laws. *Moran*, 536 U.S. at 378-79. Once again, this has applicability to funded plans, but not to disputes among third-party insurers and insureds. That liability does not rest with the employer, but with the insurer. In any event, ERISA specifically contemplates that disuniformities for national insurance plans will necessarily occur as a result of the saving clause. *Ward*, 526 U.S. at 376, n.6.

Moreover, this Court has repeatedly made clear that insurance enforcement mechanisms and laws regulating claims practices are at the core of McCarran-Ferguson and thus ERISA's saving clause. *Kentucky Association*, 123 S.Ct. at 1478, n.3 ("notice-prejudice" rule discussed in *Ward* fell within saving clause because it directly affected insurer's claims processing function.); *Ward,* 526 U.S. at 374 n.5 (stating that "laws regulating claims practices . . . [are included] in catalogue of state laws that regulate insurance."); *Metropolitan Life,* 471 U.S. at 744 (type of state regulation encompassed by McCarran-Ferguson, includes "enforcement").

Thus, a careful look at the structure of the remedial provisions of ERISA shows, if anything, that the act was intended to be enforced exactly as written – i.e., that all state laws regulating insurance, including remedial laws, are saved from preemption. This is entirely consistent with ERISA's purpose. ERISA imposes substantive regulations on, and provides direct actions against, funded plans. Yet, it does not provide substantive regulations against unfunded welfare plans and thus permits direct state actions against the parties ultimately responsible for the payment of benefits. This is also consistent with the long-standing principles of field preemption, whereby Congress does not intend to completely preempt a field without inserting substantive federal regulations in place of the existing state regulations.

B. Nothing In The Legislative History Supports A Conclusion That Congress Intended To Preempt State Remedial Laws That Are Saved From Preemption.

Pilot Life also discussed ERISA's legislative history. Yet, as set forth at length below, there is nothing in the legislative history of the Act to support a conclusion that ERISA was intended to preempt remedies that were explicitly saved from preemption. The principle piece of legislative history referred to in *Pilot Life* is the Conference Report's reference to the Labor-Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 185. 481 U.S. at 55. The *Pilot Life* Court found this statement to reflect Congress' intent to compare ERISA's preemptive effect with the powerful preemptive force of Section 301 of the LMRA. *Id*. Once again, this may apply with regard to laws of general applicability or laws relating to funded pension benefits; however, it has no bearing with respect to a law that falls within the saving clause. The LMRA has no saving clause and thus is not comparable legislation when addressing a law that is specifically saved from preemption. Indeed, this Court has made this very point.

This Court has repeatedly pointed out that the saving clause is just as broad as the preemption clause. *Ward*, 526 U.S. at 363; *Metropolitan Life*, 471 U.S. at 733. Thus, the remedial clause cannot serve to trump the saving clause simply because of reference in the legislative history to the LMRA.

> The phrasing of § 502 [ERISA's remedial provision] is instructive. . . . It does not purport to reach every question relating to plans covered by ERISA . . . *Furthermore, § 514(b)(2)(A) of ERISA [the savings clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans.* With important, but express limitations, it states that 'nothing in this subchapter shall be construed to relieve any person from any law of any State which regulates insurance, banking, or securities.' *In contrast*, § 301(a) of the LMRA applies to all 'suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce . . . or between any such labor organizations.'

Franchise Tax Board of State of California v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 25 (1983) (emphasis added).

Even the *Pilot Life* decision makes this clear. In citing to the legislative history, the Court quoted one of the bill's sponsors, Senator Williams, as follows: *"[W]ith the narrow exceptions specified in the bill*, the substantive and enforcement provisions of the conference substitute are intended to preempt the field. . . ." 481 U.S. at 46 (emphasis added). Manifestly, the saving clause is the principal exception.[16] Moreover, Senator Williams' statement, as well

[16] Reference in Senator Williams' remarks to the "narrow" exception is "far too frail [to] support" a restricted reading of the saving clause. *Metropolitan Life*, 471 U.S. at 746.

as those of the other sponsors of the bill,[17] were made in the context of the intended purpose of the Act as pension reform legislation.

Once again, the Solicitor General is in agreement with this view. The Solicitor General concluded its discussion in its *Ward* brief by pointing out that this Court's reference in *Pilot Life* to the portion of ERISA's legislative history relating to Section 301 of the LMRA "does not bear directly on the preemption of a state law cause of action or remedy that 'regulates insurance.' That is because LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision." *Ward* Br. at 25.

III. Recent Court Decisions Contain Repeated Requests That This Court Reconsider Its Dicta In *Pilot Life*.

Ever since its issuance, *Pilot Life* has led to repeated expressions of angst among courts faced with its tragic inequities. *See Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1005 (9th Cir. 1998), *cert. denied*, 120 S.Ct. 170 (1999) ("Although this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy"); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1271 (10th Cir. 1996) ("Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm [the grant of summary judgment to the insurer]"); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) ("The result ERISA compels us to reach means the Corcorans have no remedy, state or federal, for what may have been a serious mistake"); *Andrews-Clarke v.*

[17] Further, while these comments were persuasive to this Court in the context of a law of general application, they are "of little help in analyzing § 514(b)(2)(A) for . . . the saving clause is broad on its face and specific in its reference." *Metropolitan Life*, 471 U.S. at 746 n.24.

Travelers Ins. Co., 984 F. Supp. 49, 52-54, 65 (D. Mass. 1997) ("The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. . . . Under traditional notions of justice, the harms alleged . . . should entitle [her] to some legal remedy. . . . Nevertheless, this Court had no choice but to pluck [her] case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers . . . , to slam the courthouse doors in her face and leave her without any remedy. . . . Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers . . . from potential liability for the consequences of their wrongful denial of health benefits . . . [ERISA] has gone conspicuously awry from its original intent. . . . Does anyone care? Do you?" (footnotes omitted); *Florence Nightingale Nursing Serv., Inc. v. Blue Cross & Blue Shield of Alabama*, 832 F. Supp. 1456, 1457 (N.D. Ala. 1993), *aff'd*, 41 F.3d 1476 (11th Cir. 1995); *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (N.D. Ala. 1988); *see also* Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies,* 42 Santa Clara L. Rev. 105 (concluding that saving clause saves state law insurance remedies); Bogan, *Protecting Patient Rights*, *supra* note 4, at 996-1002 (contending that Supreme Court dicta in *Pilot Life* not consistent with statutory text and legislative intent); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 Harvard J. on Legis. 35, 38 (1996) ("It is a rich irony that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws.") (footnote omitted).

In *Cicio v. Does,* 321 F.3d 83, 106 (2d Cir. 2003), Justice Calabresi, in dissent, writes, " . . . the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to

the same end." Justice Calabresi suggests that ERISA's drafters

> . . . nicely "balanc[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." [cite]
>
> Or so Congress and ERISA beneficiaries fairly could have hoped. What they got instead was the Supreme Court's "Trail of Error," in which the Court lumped consequential and punitive damages into the misleading category of "extracontractual relief," [cite] and disallowed both by dint of an anachronistic (and historically false) law/equity distinction said to be implicit in Congress's provision for "appropriate equitable relief" in § 502(a)(3).

321 F.3d at 107.

Justice Calabresi urges the Court to reconsider its rulings limiting the form of relief available under ERISA. However, the crux of the problem is *Pilot Life,* as it is the lower courts' interpretation of that opinion which has divested claimants of the right to pursue claims directed specifically at insurance abuses and which would provide for compensatory damages.

In *Rosenbaum v. UNUM Life Ins. Co., supra*, the Court looked carefully at *Pilot Life* and the language in *Moran* which related to *Pilot Life*. It found the Court's discussion of Congressional intent to be "flawed in three important respects." It failed to apply the fundamental rule of statutory construction that courts must presume that a statute means what it says (*Rosenbaum* at *7-8) and ERISA's saving clause is clear on its face that "nothing," including Sections 502 and 514, can affect state laws saved from preemption. *Id.*

> Other than the obvious requirement that the law must regulate insurance, Congress placed no other requisites or restrictions on the laws saved from preemption under ERISA's saving clause. In this regard, Congress' intent was clear, it wanted all state laws which regulate insurance to be

exempt from preemption under ERISA. The *Pilot Life* and *Rush* holdings present an implied Congressional intent which flatly contradicts this express intent. Rather than allowing any state law which "regulates insurance" to survive ERISA preemption, this implied intent adds an additional requirement, that is, the law must not offer a remedy which is not listed under § 502(a). The problem with such a requirement is that the Courts have taken an implied intent, which was derived by questionable means, and have interpreted that implied intent to overrule Congress' express intent, as reflected in the saving clause. . . .

* * *

Finally, the *Pilot Life* and *Rush* Opinions disregard the fundamental presumption against implied preemption. "[T]he historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." [cite] Here, the clear and manifest purpose of Congress was memorialized in the saving clause, which provides for state regulation to be excluded from preemption under ERISA when it "regulates insurance." To find to the contrary would supplant Congress' express intent and, in the process, would violate the spirit of the Tenth Amendment, "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." U.S. Const. Amend. X

Rosenbaum at *7-9.

Justice Becker in *Difelice* also wrote in concurrence to urge this Court to reconsider its ERISA holdings, including specifically its broad preemption holding. His language is important and powerful. He notes that ERISA and Section 514 preemption have become

> . . . virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed

against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided.

* * *

This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights. . . .

* * *

The unavailability of extracontractual damages has effects that are perverse. . . . it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see, Pilot Life,* 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

Difelice, 346 F.3d at 456-462.

Justice Becker believes that the bar to extracontractual damages has led to an ERISA "preemption nightmare" and suggests that the Supreme Court revisit its preemption analysis. He explains that ERISA's legislative history, upon which *Pilot Life* is based, is hardly clear, and that the preemption clause was inserted at the last minute

and with little Congressional debate. *Id.* at 466. He concludes:

> The evidence suggests that Congress did not carefully consider whether the scope of preemption should reflect the different degrees of federal regulation of pension plans and welfare benefit plans. *See* Fisk, *The Last Article about the Language of ERISA Preemption?,* 33 Harv. J. on Legis. at 56. In my view, section 514(a)'s broad preemptive scope is sensible with regard to pension plans, for federal law fully displaces state law and provides vesting, requirements, minimum funding requirements, and a raft of other employee safeguards. However, to me, it makes much less sense with respect to welfare plans. As discussed *supra,* Congress exempted welfare benefit plans from most of ERISA's substantive regulations, such as its vesting and minimum funding requirements.
>
> As I see it, it is unlikely that Congress intentionally created this so-called "regulatory vacuum," in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute. The more likely explanation is that Congress merely intended to create minimum safeguards to protect the financial integrity of welfare benefit plans while stopping short of federalizing the entire remedial regime, especially in light of what was a workable state-law remedial system. Congress's failure to distinguish explicitly between pension and welfare benefit plans in § 514(a) is understandable, for, as explained above, the managed care plans that wreak havoc with § 514(a) as it relates to welfare benefit plans did not exist when ERISA was enacted. There is no evidence that Congress envisioned the current situation.

Id. at 467.

Undoubtedly these eminent jurists have gone to great lengths to speak out because of their firm belief that *Pilot Life* is a flawed decision and that the repeated tragic consequences of that decision are so innumerable and have gone so far as to cry out for this Court's intervention. They recognize, as we discuss below, that the legislative history is clear that Congress did not intend that ERISA preempt state laws which are saved from preemption and that to do so makes little sense.

IV. ERISA's Legislative History Is Unequivocal In Disclosing That The Act Was Intended To Regulate Pension Benefits And Was Not Intended To Impact The Field Of Insurance.[18]

As this Court has recognized, ERISA was a massive legislative undertaking. *Pilot Life,* 481 U.S. at 44. Yet, the briefing regarding the legislative history before the Court in *Pilot Life* was nearly non-existent. This Court relied on the last two pages of the Solicitor General's short brief supporting the grant of certiorari. *Id.* at 52. However, none of the other briefs in the case discussed the legislative history at all. Thus, no one sought to assist the Court in presenting the lengthy legislative history, which conflicts with that presented in the Solicitor General's original brief. Moreover, as noted above, the Solicitor General has since changed his view on the proper interpretation of ERISA's legislative history. When one views that history in context, it is plain that there is nothing in that history to support an implied Congressional intent which is contrary to the plain words of the statute itself.

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[18] *See generally* Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1976) [hereinafter "Legislative History"]; Special Comm. on Aging, U.S. Senate, 98th Cong., The Employment Retirement Income Security Act of 1974: The First Decade 1-25 (Comm. Print 1984) [hereinafter "The First Decade"].

The legislative history discussed herein is carefully and extensively set forth in greater detail in Bogan, *Protecting Patient Rights, supra,* 74 Tul. L. Rev. 951; *See also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism,* 48 U. Pitt. L. Rev. 427, 437-457 (1987).

ERISA was the direct outgrowth of the explosion in private pension plans during the middle of the last century. The number of employees covered by such plans grew from approximately 4 million in 1940 to over 30 million by 1973.[19] The estimated assets held by such plans during this same period grew from $2.4 billion to $150 billion.[20] With this explosive growth came a similarly expansive growth in the abuses of such funds.[21] In addition, the enormous accumulation of such funds exerted a major impact on the country's financial markets.[22] This explosion occurred without the benefit of any effective federal or state regulation.[23]

In 1954, at the request of President Eisenhower, Congress undertook an extensive study of the private pension industry.[24] This study disclosed abuses, including incompetent management of pension funds, looting, embezzlement, kickbacks, excessive administration costs and imprudent investment practices.[25] In response, Congress enacted the

[19] *See* S. Rep. No. 93-127, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4839-40, and in 1 Legislative History, *supra* note 18, at 589.

[20] *See* H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 2350; The First Decade, *supra* note 18, at 5; 4641, and in 2 Legislative History, *supra* note 18, at 5; James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 24 (1978).

[21] *See* 120 Cong. Rec. 29,934 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (statement of Sen. Javits); The First Decade, *supra* note 18, at 6 n.22 (citing congressional hearings on abuse in pension plan administrations); *see also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, *supra* note 18, at 443-45 (referring to the many abuses in employee pension plans listed in ERISA's legislative history).

[22] *Id*; H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 18, at 2350.

[23] *See* note 17 *supra*.

[24] *See* S. Rep. No. 85-1440, at 2-11 (1958), *reprinted in* 1958 U.S.C.C.A.N. 4137.

[25] *Id*. at 4137-47

Welfare and Pension Plans Disclosure Act in 1958.[26] This law merely required the disclosure of certain financial information to the employees and did not provide any meaningful regulation of the funds themselves.[27]

This legislation was wholly ineffective.[28] Consequently, in 1962 President Kennedy appointed a special task force to study the problem.[29] The task force concluded that further federal regulation of private pension plans to include mandatory minimum vesting and funding requirements was necessary and that further study was required on other issues.[30] Significantly, the task force specifically did not investigate or consider any reforms of nonpension plans, such as health insurance plans.[31] In response to these concerns, New York Senator Jacob Javits

[26] Pub. L. No. 85-836, 72 Stat. 997 (1958) (repealed 1974).

[27] *See* H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 18, at 2351; *Malone v. White Motor Corp.*, 435 U.S. 497, 507 (1978) (plurality opinion).

[28] *See* S. Rep. No. 93-127, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4841; H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 18, at 2351.

[29] *See* President's Comm. on Corporate Pension Funds and Other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans, at vii-viii (1965) [hereinafter "President's Committee Report"]; *see also* The First Decade, *supra* note 16, at 8-10 (describing the formation of the committee and its findings).

[30] *Id*.

[31] *See* President's Committee Report, *supra* note 27, at iv ("Although the area of investigation assigned to the Committee included welfare plans as well as retirement programs, the President's memorandum specifically raised questions about issues which arise primarily from retirement plans. Other types of welfare plans, such as health and insurance plans, make important contributions to the economic security of American workers; they do not, however, have the impact of pension plans on accumulation of savings, labor mobility, and similar matters touched upon by the President. Consequently, the Committee has confined its efforts to an inquiry into private employee retirement plans (i.e. excluding plans for self-employed persons) without any extensive study of other types of welfare plans.").

introduced legislation in 1967 to create federal funding and participation requirements for private pension plans.[32] This led to further Congressional investigations and eventually ERISA. In 1970, the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare began a three-year study "undertaken to ascertain the need for statutory protections for workers' pension programs and to formulate appropriate corrective legislation."[33] Like the previous investigations, the subcommittee's hearings disclosed a morass of abusive practices resulting in the loss of retirement benefits to employees as the result of inadequate funding, mismanagement and unreasonable vesting requirements.[34] It agreed with President Kennedy's task force and recommended comprehensive regulation of the pension industry.[35] Shortly thereafter, Senator Javits introduced Senate Bill 4. It stated, "[t]he purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems which have been determined by the Senate Subcommittee's comprehensive study of such plans."[36] A corresponding House bill was also introduced.[37]

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[32] *See* 113 Cong. Rec. 4650-53 (1967) (statement of Sen. Javits); *see also* 120 Cong. Rec. 29,933-34 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (remarks of Sen. Javits) (recounting his continued efforts to reform the private pension and welfare system).

[33] *See* S. Rep. No. 92-634, at 1 (1972); *see also* 119 Cong. Rec. 30,003 (1973), *reprinted in* 2 Legislative History, *supra* note 18, at 1598 (statement of Sen. Williams).

[34] *See* H.R. Rep. No. 93-533, at 5-8 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4639, 4643-46, and in 2 Legislative History, *supra* note 18, at 2355.

[35] *See* 120 Cong. Rec. 29,935-44 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (remarks of Sen. Javits).

[36] S.4, 93d Cong. (1973); *see* S. Rep. No. 93-127 (1973), at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4838, and in 1 Legislative History, *supra* note 18, at 587.

[37] *See* H.R. 2, 93d Cong. (1973), *reprinted in* 1 Legislative History, *supra* note 18, at 3.

These bills were sent to their appropriate committees, which issued their own reports. Each of these reports concerned themselves solely with abuses in and the consequent need for regulation of private pension plans.[38] The Senate Committee on Labor and Public Welfare report states:

> The provisions of S.4 are addressed to the issue of whether American working men and women shall receive private pension plan benefits which they have been led to believe would be theirs upon retirement from working lives. It responds by mandating protective measures and prescribing minimum standards for promised benefits. The purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems . . . .[39]

The report states that "[t]he principal issues affecting the vital and basic needs for legislative reform involve consideration of the essential elements of pensions: (1) 'vesting,' (2) 'funding,' (3) 'reinsurance,' (4) 'portability' and (5) 'fiduciary responsibility and disclosure.'"[40] Similarly, the House Committee on Education and Labor report states that the "primary purpose of the bill is the protection of individual pension rights" and that the legislation was designed to: (1) establish minimum fiduciary standards for retirement plans, (2) provide for enforcement and public disclosure of finances, (3) improve the equitable

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[38] *See* S. Rep. No. 93-127, at 1-36, *reprinted in* 1974 U.S.C.C.A.N. at 4838-89, and in 1 Legislative History, *supra* note 18, at 587-622; H.R. Rep. No. 93-533, at 1-28, *reprinted in* 1974 U.S.C.C.A.N. at 4639-70, and in 2 Legislative History, *supra* note 18, at 2348-75; 120 Cong. Rec. 29,933-35 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4746-51 (remarks of Sen. Javits).

[39] S. Rep. No. 93-127, at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 18, at 587.

[40] S. Rep. No. 93-127, at 8-11, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 18, at 594-97 (emphasis omitted).

character and soundness of private pension plans by requiring (a) appropriate vesting and (b) minimum funding standards, and (4) guarantee the adequacy of the plan's assets prior to termination.[41]

ERISA's legislative history is unequivocal that it was intended as a pension reform bill. In describing ERISA, Senator Javits said, "[T]he pension reform bill is the greatest development in the life of the American worker since social security. For the first time in our history most workers will be able to truly retire at retirement age and live decently on their social security and private pensions."[42] Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, described his committee's study which lead to ERISA. "This study clearly established that too many workers, rather than being able to retire in dignity and security after a lifetime of labor rendered on the promise of a future pension, find that their earned expectations are not to be realized."[43] In the House, one of the principal proponents, Representative Dent, described ERISA's purpose in this way: "[W]e started out with only one aim in view and that was to give a pension participant his entitlements under the contract of the pension plan he belonged to."[44] The record is filled with tragic examples of workers deprived of pension benefits after 30, 40 and 50 years of employment because they were a few days short of vesting before retiring, the company was sold or went bankrupt, or because the

[41] H.R. Rep. No. 93-533, at 1, 17-18, *reprinted in* 1974 U.S.C.C.A.N. at 4655-56, and in 2 Legislative History, *supra* note 18, at 2348, 2364-65.

[42] Legislative History, *supra* note 18, at 4747 (Remarks of Sen. Javits).

[43] Legislative History, *supra* note 18, at 4733 (Remarks of Sen. Williams).

[44] Legislative History, *supra* note 18, at 4665 (Remarks of Rep. Dent).

employer could not afford to pay the promised retirement benefits.[45]

While this Court has referred to ERISA as a "comprehensive and reticulated statute,"[46] it is so only with respect to pension plans, and the Court's description of the Act as such a statute originated in the context of pension cases.[47] The Act substantially regulated pension plans but contained virtually no meaningful regulation of insurers or insurance "plans."

What is clear from this long and extensive legislative history and the statute itself is that the exclusive concern of Congress in passing ERISA was to address abuses in the pension field. Not a single insurance concern is expressed anywhere in the legislative history. Instead, Congress expressly saved all insurance regulation to the States. This Court has endorsed this view, noting that the broad preemption clause was added at the last minute, that there is no legislative history discussing the relationship between the saving clause and the general preemption clause, and that there is a "complete absence of evidence" to support a narrow reading of the saving clause. *Metropolitan Life*, 471 U.S. at 745-46 n.21. As one commentator who has extensively reviewed ERISA's legislative history reports,

> . . . ERISA's legislative history is remarkable . . . for what it does not contain. ERISA's legislative

[45] *See, e.g.*, Legislative History *supra* note 18, at 4749-50 (Remarks of Sen. Javits on "Why Pension Reform Is Needed), (4791-96 (Remarks of Sen. Bentson), (4664-65) (Remarks of Rep. Thompson), (4710) (Remarks of Rep. McClory); *Interim Report of Activities of the Private Welfare and Pension Plan Study, Subcommittee On Labor of the Committee on Labor and Public Welfare*, S. Rep. No. 92-634, 92d Cong., 2d Sess. (1972) at 67-90.

[46] *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981); *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980).

[47] *Id.*

> history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans.
>
> * * *
>
> There is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of nonpension benefit plans, or of any specific concern with the management of nonpension plan assets. Further, ERISA's legislative history fails to disclose any concerted investigation of any complaints about nonpension benefits, such as inadequate health care, accident, death or disability coverage, or problems with health, life, or disability benefits claims. In short, Congress just was not dealing with nonpension benefit plans when it enacted ERISA.

Bogan, *Protecting Patient Rights, supra,* note 4 at 972, 976-77.

CONCLUSION

ERISA's statutory history as pension reform legislation is unequivocal. Its language saving any state law regulating insurance is unambiguous and, because ERISA was not intended to regulate insurance, it fails to provide a meaningful remedy to resolve insurance disputes. As many Courts and commentators have now requested, this Court should revisit the wisdom of its dicta in *Pilot Life* and disapprove the analysis set forth therein.

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In the Supreme Court of the United States

AETNA HEALTH INC.,
Petitioner,

v.

JUAN DAVILA
Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.
Petitioner,

v.

RUBY R. CALAD, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF TEXAS, CALIFORNIA, CONNECTICUT, DELAWARE, ILLINOIS, KANSAS, LOUISIANA, MARYLAND, MINNESOTA, MISSOURI, MONTANA, NEVADA, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PUERTO RICO, UTAH, VERMONT, WASHINGTON AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

The Texas Health Care Liability Act creates a tort cause of action against an HMO that negligently renders a medical decision that affects the quality of a patient's treatment and results in injury to the patient. ERISA §502(a) provides a set of civil-enforcement remedies whereby ERISA plan participants can obtain plan benefits or otherwise enforce their contractual rights under ERISA plans. In enacting §502(a), did Congress clearly and manifestly intend to displace state-law tort claims for HMOs' negligent medical decisions with such preemptive force as to transform those claims into federal actions under ERISA removable to federal court?

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INTEREST OF *AMICI*

The State *amici curiae*, through their Attorneys General, respectfully submit this brief in support of Respondents. States have a vital interest in protecting their power to regulate traditional areas of state concern, such as the health and safety of their citizens. Nothing in the Employee Retirement Income Security Act of 1974 (ERISA) evidences an intent to eliminate the States' role in regulating health care. *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). Thus, the States have an interest in ensuring that ERISA's preemption provisions are not construed more broadly than Congress intended.

Texas Health Care Liability Act §88.002(a) directly serves the State's interest in protecting the health and safety of its citizens. It provides a cause of action against a health maintenance organization (HMO) that breaches its duty to exercise ordinary care when making health care decisions that affect the quality of a patient's treatment. The State, in its role as regulator of health care, has determined that when an HMO assumes responsibility for making medical-necessity decisions involving the exercise of medical judgment, and that direction results in personal injury, the HMO should be held responsible for its erroneous medical judgment. Following Texas's lead, nine other States have passed managed care liability laws, others have passed some form of consumer protection from HMO actions, and an increasing number of state legislatures have contemplated new liability legislation.

The HMO-petitioners in this case claim that their allegedly negligent medical decisions can be redressed only through the contractual remedies provided in ERISA §502(a). If this contention is correct, then HMOs enjoy immunity from any harm proximately resulting from their medical negligence by virtue of a statute that was not designed to regulate health care providers. The State *amici curiae* ask the Court to hold that Congress did not clearly and manifestly intend that §502(a)'s remedies would completely preempt States' traditional role in regulating health care quality standards.

SUMMARY OF THE ARGUMENT

Protecting the health and safety of her citizens is the principal obligation of each and every state government. For this reason, regulating health care has long been a traditional area of state concern, manifested in statutory and common law safeguards against negligent and harmful medical care.

Congress, in enacting the Employee Retirement Income Security Act of 1974 (ERISA), did nothing to change that.

Modern HMO practice, unforseen in 1974, has resulted in managed care providers routinely making medical judgments and decisions. As this Court explained in *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000), HMO "medical necessity" determinations implicate both "eligibility" and "treatment," and the two "are often practically inextricable from one another." And the result of these mixed "medical necessity" decisions often dictates the course and quality of a patient's health care.

Responding to the need to ensure that patients are protected from negligent and wrongful conduct by HMOs, Texas and nine other States have adopted some form of HMO-liability statute. These statutes do not seek to mandate the specific terms of particular HMO plans, but rather to bring day-to-day HMO medical treatment determinations back into the ambit of ordinary standards of care. In this case, the Texas Health Care Liability Act provides such scrutiny, within a state framework that entitles HMOs to significant procedural protections, including in many circumstances requiring independent review before suit may be brought.

When insurance companies act as medical professionals, and make medical judgments, these States have determined that they should be subject to medical standards of care. Aetna and CIGNA urge this Court to read ERISA §502(a) to insulate them from any legal scrutiny, so that negligent or wrongful medical decisions by HMOs would be immune from liability.

ERISA provides no basis to do so. In urging complete preemption under §502(a), Petitioners face an extremely high threshold: this Court has "worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act *unless that was the clear and manifest purpose of Congress*." *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (internal quotation and citation omitted) (emphasis added).

Petitioners have presented no compelling argument that Congress had a "clear and manifest purpose" to completely preempt state health care liability for HMOs making medical judgments. Congress did not anticipate modern HMO practice, much less clearly intend to create a "'regulatory vacuum,' in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute." *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 467 (CA3 2003) (Becker, J., concurring).

Were Aetna and CIGNA to prevail, patients would be left with no meaningful remedy for negligent and wrongful medical decisions made by HMOs. ERISA would not provide relief, and the health care laws of sovereign States would be completely preempted from providing those protections. This Court's precedents do not compel such an outcome, nor does any "clear and manifest" intent of Congress.

ARGUMENT

I. THE TEXAS HEALTH CARE LIABILITY ACT (THCLA), PROVIDES A TORT CAUSE OF ACTION FOR PATIENTS INJURED BY AN HMO'S NEGLIGENT MEDICAL DECISIONS THAT AFFECT THE QUALITY OF TREATMENT.

A. In Making Mixed Eligibility and Treatment Decisions, HMOs Exercise Professional Medical Judgment That Affects the Quality of Treatment.

Managed care providers, including HMOs, perform two distinct functions: (1) the preparation and administration of benefits plans and (2) the provision of medical treatment to plan beneficiaries. Some HMOs employ doctors and provide medical services directly; others contract with a network of doctors to provide medical services based on a single reimbursement plan. In either case, when HMOs make a decision whether to cover a particular patient's medical care, they blend these two roles, making what this Court has called a "mixed" determination of both "eligibility" and "treatment." *See generally Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). That is, every time an HMO determines whether a particular medical treatment is "medically necessary," and therefore covered by the benefit plan, it exercises some degree of medical judgment, albeit mixed with questions of plan administration. *See, e.g., DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (CA3 2003). Because HMOs make this determination prior to or at the point of treatment, they can and do affect the quality of medical treatment afforded plan beneficiaries.

1. Any "medical necessity" determination necessarily involves medical judgment.

The Court has recognized that HMO "medical necessity" determinations, though made in the course of assessing coverage under ERISA-qualified health plans, involve an element of professional medical judgment that bears on treatment. In *Pegram v. Herdrich*, the Court addressed the nature of these determinations in considering whether an HMO-employed doctor acted as a fiduciary for ERISA purposes in providing medical services under an ERISA-qualified plan. *Pegram*, 530 U.S., at 215. In aid of its analysis, the Court initially identified two categories of "arguably administrative" acts by HMOs: (1) "Pure eligibility decisions," which "turn on the plan's coverage of a particular condition or medical procedure for its treatment;" and (2) "Treatment decisions," which are "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.*, at 228.

The Court concluded that HMOs' "medical necessity" determinations implicated both "eligibility" and "treatment":

> "These decisions are often practically inextricable from one another . . . . This is so not merely because, under a scheme like [Petitioners'], treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions . . . . The more common coverage question is a when-and-how question. . . . The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case." *Id.*, at 228-29.

Thus, the mere fact that the HMO in *Pegram* had made "medical necessity" a condition of coverage did not render that inquiry a contractual question of eligibility under the plan or ERISA. Quite the contrary, the treatment aspect of the decision removed the "medical necessity" determination from the ambit of ERISA fiduciary obligations altogether. *Id.*, at 237. Instead, the Court indicated that these sort of decisions implicated state medical malpractice law, *see id.*, at 235-37, which generally provides standards of care and liability schemes governing health-care professionals.

Moreover, the Court made clear that the "mixed" nature of the "medical necessity" determination did not turn on the fact that the HMO provided medical services through physicians it employed. *Id.*, at 228 (noting that decision is mixed "not merely" because HMO-employed physician made both treatment and eligibility decisions). In the Court's example, it observed that these "mixed" decisions are involved in whether the HMO will "provide *or pay*" for a particular procedure at a particular time. *Id.*, at 229. In other words, a third-party network-HMO whose ultimate role may be only to pay or not to pay for treatment still engages in a mixed decision involving treatment questions. It is the *nature* of "medical necessity" determinations—the "when-and-how" questions—and not who makes them that renders them in part an exercise of medical judgment that is traditionally subject to state regulatory control. *See id.*, at 228-29.

2. In making "medical necessity" determinations, HMOs can and do dictate the quality of a patient's treatment.

Unlike the processing of claims for most categories of ERISA benefits, such as pension, disability, and death benefits, HMOs make eligibility decisions *before* the events giving rise to benefit claims—*i.e.*, either prior to or at the point of medical treatment. This arrangement creates a window between diagnosis and treatment

in which the HMO's "medical necessity" determinations can affect the quality of treatment the patient receives, with potentially harmful or even fatal consequences. Davila's and Calad's cases both demonstrate how this can occur.

a. Medical-necessity judgments made by HMOs in structuring benefit plans and in applying utilization review dictate medical treatment.

HMOs engage in *ex ante* medical-necessity judgments in drafting their own plan requirements. The HMOs develop and market packaged benefits arrangements, which offer varying levels of coverage for varying prices per covered beneficiary. This package is marketed, not to the beneficiaries directly but to the ERISA-plan established by the beneficiaries' employer. Although HMOs have the right to draft treatment plans that do not cover particular treatments, when an HMO chooses to provide coverage for a range of treatments, or to mandate a set of pre-certification requirements for particular treatments, it makes an inherent medical judgment that can dictate the course of treatment.

In this regard, the HMO makes judgments that various treatments are sufficiently equivalent that one can be replaced with the other, or that the patient *must* attempt a less expensive treatment before the HMO will consider covering a more expensive option for the same illness. These determinations involve a medical assessment of the health risks and benefits of favoring one treatment over another. In addition, questions of effectiveness and the possibility of side effects are essential to drawing up such multi-tiered coverage options. By indicating that certain treatments are equivalents, or that a patient must follow a certain course of treatment before other options will be covered, the HMO interjects itself into the treatment decision-making process.

HMOs' medical-necessity decisions also dictate treatment through the "utilization review" process, by which the HMO determines payment-eligibility *before* a medical professional actually provides treatment. When an HMO reviews a patient's treatment based on that patient's individual condition to determine what treatment is "medically necessary," it mirrors exactly the decision made by the treating physician. The only difference is that the HMO characterizes its decision as interpretation of a contract, while the doctor, by virtue of a state-issued medical license, is subject to a professional standard of care designed to protect patient safety. In practice, however, this is a distinction without a difference.

Although the terms of the HMO agreements make clear that medical professionals are not *prevented* from providing care that the HMO determines is not "medically necessary," the assumption that these contractual agreements do not impact medical treatment decisions ignores the inability of most HMO beneficiaries to pay for critical procedures out-of-pocket:

> "[I]n many cases, participants must take HMOs' decisions as law—for example, when Aetna's utilization review board denied coverage for DiFelice's specialized tracheostomy tube, he faced the decision whether to pay for the specialized tube out-of-pocket, whereas appealing the HMO's decision was simply impractical in the face of a medical emergency. In such cases, the critical insight is that the HMO *de facto* determines a patient's *actual treatment* along with his eligibility for benefits, for it will be a relatively rare person who is able to pay for invasive procedures out-of-pocket." *DiFelice*, 346 F.3d, at 464 (Becker, J. concurring).

In such situations, even a small difference in the quantum of care provided can make the difference between a patient who survives an emergency and one who does not. Therefore, contrary to CIGNA's assertions, *see* CIGNA Br., at 28, the difference between payment decisions made before and after treatment does affect the treatment

and health of the patient-beneficiary. It can be the difference between life and death.

b. In these cases, the HMOs' medical-necessity determinations dictated Davila's and Calad's treatment.

Davila's and Calad's cases represent two instances in which their HMOs' medical-necessity determinations allegedly dictated the course of their treatment.[1] Davila's doctor proscribed a drug called Vioxx to treat his arthritis pain and sought pre-certification for the prescription from Aetna. Pet. App. 77a. Aetna's pharmacologist advised Davila's doctor that the Aetna plan would cover Vioxx "only if the member has already tried—or cannot try, because of allergy or contraindication—at least two of the fifteen other, *similar* drugs that are listed on the formulary." Aetna Br., at 9 (emphasis added). In so doing, Aetna had already made the medical determination that the other drugs on the formulary were "similar" to Vioxx and that it would be acceptable for a patient to use those drugs unless he had a known allergy or contraindication. Necessarily, Aetna dictated that a patient was *required* to use two of those drugs—and that those treatments would have to fail—as a precondition to providing coverage for Vioxx. Again, Aetna had made the medical determination that, absent a known allergy or contraindication, the use and failure of two of these drugs was an acceptable risk for a patient to endure as part of its formulary program.

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1. The *Amici* States express no opinion as to the truth of the allegations in Davila's and Calad's complaints. This brief assumes the truth of those allegations—that the HMOs' medical decisions were in fact negligent—only for purposes of assessing federal-question jurisdiction under the well-pleaded complaint rule. *See Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9-12 (1983).

Aetna points out that Davila failed to exercise certain remedies available to him when it denied coverage for Vioxx: (1) filing a grievance with Aetna, (2) appealing Aetna's decision to an Independent Review Organization (IRO), or (3) filing a lawsuit under ERISA §501(a)(1)(B) to compel payment. Aetna Br., at 9. Of course, none of these options addresses how Davila could treat his arthritis pain while he pursued these remedies; as Aetna admits, the grievance and IRO procedures could be expedited only if Davila's condition were life-threatening. *Id.* Thus, at that time, Davila's treatment options were: (1) continue to suffer arthritis pain; (2) find a way to pay for the Vioxx prescription himself, if possible; or (3) use another drug to relieve his pain. In practice, Davila's available course of medical treatment was to try another drug, and naturally, his doctor chose one that Aetna directed he try as a precondition to coverage for Vioxx: Naprosyn. *See* Pet. App. at 68a.

Apparently, Davila's use of this drug adhered precisely to the dictates of Aetna's plan. He had no known contraindication or allergy with respect to Naprosyn. He tried the drug and it failed, leaving him with one more drug treatment to attempt and fail before Aetna would considering covering the medication his doctor originally prescribed. But the consequences were devastating: as a result of Aetna's mandated administration of an alternate drug, Naprosyn, Davila was hospitalized and diagnosed with bleeding ulcers. Pet. App. 68a. In this way, through its medical-necessity determinations, Aetna affected the quality of the *immediate* treatment for Davila's arthritis—regardless of whether he initiated a grievance, appeal, or ERISA remedy—and that treatment resulted in concrete harm.

Similarly, Calad entered the hospital for a hysterectomy with reconstructive surgery, and her doctor determined that she needed to stay in the hospital for more than twenty-four hours. CIGNA Br., at 3. CIGNA's utilization review organization—staffed by nurses and consulting physicians—determined that hospitalization beyond

twenty-four hours was not "medically necessary," and therefore, not covered under the CIGNA plan. *Id.*, at 3-4. In other words, CIGNA engaged in precisely the same medical evaluation as Calad's doctors had done, but reached a different medical judgment.

Like Aetna, CIGNA points out that Calad did not file a grievance or an appeal to an IRO to review CIGNA's determination. *Id.*, at 4. Again, however, those options failed to address how Calad could continue to receive treatment once her hospital stay extended beyond twenty-four hours. Thus, Calad's treatment options in the twenty-fifth hour were: (1) return home against the advice of her treating physician; or (2) pay for the hospitalization out-of-pocket. Calad was unable to pay for the additional hospital stay herself, so her only "treatment" alternative was to return home. *Id.*, at 4. Calad developed medical complications within a few days. *Id.* In this manner, CIGNA's medical-necessity determination dictated the immediate course of Calad's treatment once she had been in the hospital for twenty-four hours.

B. Texas and Nine Other States Regulate HMOs in Making Medical-Necessity Determinations That Affect the Quality of Treatment Available Under Their Health Plans.

Texas and nine other States have now adopted some form of HMO-liability statute[2] to address the fact that HMOs exercise

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2. Ten States have passed managed care liability laws: Arizona, California, Georgia, Louisiana, Maine, New Jersey, Oklahoma, Texas, Washington, and West Virginia. *See* ARIZ. REV. STAT. §20-3153; CAL. CIV. CODE §3428; GA. CODE ANN. §51-1-48; LA. REV. STAT. §22:3085; ME. REV. STAT. tit. 24-A, §4313; N.J. STAT. 2A:53A-33; OKLA. STAT. tit. 36, §6593; TEX. CIV. PRAC. & REM. CODE §88.002; WASH. REV. CODE ANN. §48.43.545; W. VA. CODE ANN. §33-25C-7. Other States may impose similar liability schemes through their common law. The National Conference of State Legislatures maintains a website containing

medical judgment in the same manner as doctors and nurses, and those judgments can and do affect the quality of patients' treatment, with potentially harmful consequences. Such legislation clearly falls within the States' traditional province of regulating medical care for the health and safety of their citizens.

The Texas statute, the Texas Health Care Liability Act (THCLA), generally imposes a duty on HMOs and other managed care entities to exercise ordinary care in making medical determinations at the point of treatment that affect the quality of treatment. TEX. CIV. PRAC. & REM. CODE §§88.001(4), .002(a). And it creates a cause of action when the HMO fails to exercise such care and thereby proximately causes injury to a patient. *Id.*, §88.002(a), (b). Thus, contrary to Aetna's and CIGNA's contentions, the THCLA does not simply create a tort for the denial of benefits. Instead, it is carefully crafted to address situations such as Davila's and Calad's—where the HMO negligently exercises medical judgment during the treatment window in which the claims review process could not have been completed.

1. In most circumstances, the THCLA requires HMOs to submit to an independent review procedure.

Texas managed care beneficiaries, as a general matter, do not have the right to bring suit against their managed care entities. They must first either (1) exhaust the appeals and review provisions of their health care plan or (2) submit their claims for review by an independent review organization if the managed care entity participates in such a program. TEX. CIV. PRAC. & REM CODE §88.003(a), (c); *see also Corporate Health Ins. v. Tex. Dep't of Ins.*, 215 F.3d 526 (CA5 2000), *rev'd in part, remanded sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935 (2002), *opinion*

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current and pending legislation at www.ncsl.org/programs/health/liable.htm (last visited January 9, 2004).

modified and reinstated, 314 F.3d 784 (relying on *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)). In its first few years, this independent review process has dealt with successively greater numbers of challenges to HMO eligibility determinations, and has thus helped to ensure proper provision of care. *See* www.ama-assn.org/amednews/2001//05/28/gvsa0528 .htm (last visited January 12, 2004).

However, if a plan beneficiary can demonstrate that (1) harm has already occurred because of the HMO's actions and (2) the independent review process would not be beneficial, the beneficiary may bring suit directly against the managed care entity. TEX. CIV. PRAC. & REM. CODE §88.003(f).[3] Thus, Texas law does not expose HMOs to potential liability for their medical decisions until a patient-beneficiary has already been harmed by an HMO's act or omission. And it does so only when the HMO's decision has harmed a beneficiary before the applicable appeals and independent review process can be completed.

2. To complement the independent review process, the THCLA imposes a duty on HMOs making "health care treatment" decisions but does not create an obligation to provide coverage not described in the HMO plan.

HMOs are subject to voluntary participation in Texas's independent review process. However, as explained *supra*, in some cases the harm caused by the HMO occurs before the review process can be completed. To fill this gap, the THCLA imposes a duty of ordinary care on managed care entities that make medical decisions.

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3. Section 88.003(f) renders irrelevant the fact that Calad and Davila did not complete the HMO's internal appeals processes or apply for independent review of their cases. TEX. CIV. PRAC. & REM. CODE. 88.003(f).

TEX. CIV. PRAC. & REM. CODE §§88.002(a), .003(f). It also creates vicarious liability for torts committed by an HMO's agents and ostensible agents or "representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care." *Id.*, §88.002(b). Thus, the THCLA imposes a duty of ordinary professional care on an HMO to the extent that its actions harm a patient based on the predetermination of benefits without exercising an adequate level of care.

Aetna and CIGNA erroneously assert that all Davila or Calad need do to recover under the THCLA is establish that the treatment they were denied was actually covered by their respective plans. Aetna Br., at 18; CIGNA Br., at 11; *see also* U.S. Br., at 20. In this regard, they assume that the only source of a duty involved in Davila's and Calad's claims was the terms of the plan. The THCLA, however, imposes liability for failure to follow professional standards of ordinary care, not for failure to fulfill the benefit-plan agreement.[4]

Likewise, the United States mistakenly urges that the THCLA only creates an additional remedy for the HMO's failure to provide a plan benefit, and so a plaintiff need only establish that a particular treatment was covered by the plan in order to be entitled to relief. *See* U.S. Br., at 20-21. If Texas law functioned in this manner, it would effectively establish a minimum coverage requirement under state law, imposing liability on HMOs for designing plans that provide less care than the prevailing professional standard. But the

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4. This conclusion is underscored by the fact that the THCLA creates remedies only for injury that occurs before plan payment. *See* TEX. CIV. PRAC. & REM. CODE §§88.001(5), .002 (imposing liability only for decisions made "when medical services are actually provided"). This limitation prevents the law from applying to "pure eligibility" decisions. *See* discussion *supra*, Part I.A.1.

plain text of the THCLA *prevents* this outcome, by establishing that the provision will not be read to impose an obligation to cover treatment that is not covered by the agreed health plan. TEX. CIV. PRAC. & REM. CODE §88.002(d). The THCLA does not operate to create substantive standards for HMO health care benefits. It does not punish HMOs for excluding coverage for particular treatments or illnesses. Instead, the THCLA imposes a duty of care in establishing the available treatment options under HMO plans and ensures that HMOs administer those plans consistent with sound medical judgment, within the terms of the HMO agreement.

In sum, the THCLA contemplates that HMOs' medical-necessity determinations will be evaluated to determine whether they comport with professional standards of ordinary care, not whether they adhered to the terms of the plan. The operative question is not whether the treatment at issue was within the plan's coverage, but whether the HMO acted in a manner consistent with professional norms of conduct for a reasonably prudent HMO.[5]

The difference in the source of the obligation makes a difference in the remedy asserted. The tort remedy created by the THCLA compliments the state-law independent review process by creating

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5. Under Texas law, the scope of professional duty must be established on the basis of expert testimony regarding the appropriate standard of care to be used in similar circumstances. *Rehabilitative Care Sys. of Am. v. Davis*, 73 S.W.3d 233, 233 (Tex. 2002); *Bowles v. Bourdon*, 219 S.W.2d 779, 782 (Tex. 1949). Therefore, under the THCLA, the applicable standard of care would be that of a similarly situated medical care institution making a similar determination, not the standard for an individual medical professional. *See Birchfield v. Texarkana Mem'l Hosp.*, 747 S.W.2d 361, 366 (Tex. 1987). Aetna and CIGNA would therefore be held to the standard of care for an HMO, not for an individual doctor, and that standard will presumably account for the circumstance that they are providing medical care in the context of creating and administering a cost-controlled medical benefits program.

a coordinate duty to the ERISA obligation to administer the plan as a fiduciary. While the independent review procedure helps to ensure that claims are fairly resolved, the tort remedy serves to promote careful medical decision-making. These are different goals, reached by different means.

The independent review process has continued to expand, and has effectively reversed or adjusted many HMO benefits determinations. The tort remedy, however, has not been widely used. Indeed, the only two jury verdicts so far rendered under the THCLA resulted in one jury award of punitive damages and one exoneration. Mark A. Hall & Gail Agrawal, *The Impact of State Managed Care Liability Statutes*, HEALTH AFFAIRS, Sept./Oct. 2003, at 138, 141. This scant use of the statute refutes Aetna's and CIGNA's warnings that the THCLA and laws like it will ruin HMOs by imposing liability whenever patients are unsuccessfully treated under HMO-provided medical benefit plans.

II. CONGRESS DID NOT CLEARLY AND MANIFESTLY INTEND TO DISPLACE STATE TORT LAWS LIKE THE THCLA WITH SUCH PREEMPTIVE FORCE AS TO TRANSFORM THEM INTO FEDERAL ACTIONS UNDER ERISA.

Davila's and Calad's THCLA claims do not target eligibility determinations under their respective health plans, but the negligent exercise of medical judgment by their HMOs that affected the quality of their immediate medical treatment. Davila and Calad do not seek redress for the improper processing of benefits claims, or to enforce rights guaranteed them by ERISA, but to recover damages for personal injuries proximately caused by their HMOs' negligent medical judgment and the resulting impairment of their medical treatment. The question presented in this case is whether Congress, in establishing a scheme of civil-enforcement remedies in ERISA §502(a), intended to displace state-law claims of this nature with such preemptive force as to transform them into federal actions

under ERISA, thereby permitting their removal to federal court. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

Because the state law in question regulates health care, a subject of traditional state regulation, Aetna and CIGNA have a significantly elevated burden to demonstrate the requisite congressional intent to preempt—they must show that preemption was "the clear and manifest purpose of Congress." *See infra*, Part II.A. But they have failed to direct the Court to any such clear and manifest congressional intent. Davila's and Calad's state-law claims do not fall within the contours of congressionally mandated preemption as it has been defined by the Court. *See infra*, Part II.B. Furthermore, Aetna and CIGNA have not shown that Congress clearly and manifestly intended for those contours to extend to the area of core State powers implicated by Davila's and Calad's claims. *See infra*, Part II.C.

A. Aetna and CIGNA Must Show That Congress Clearly and Manifestly Intended To Completely Preempt State-Law Health-Care Liability Claims.

As discussed in Part I, the THCLA regulates the provision of health care in the State of Texas by (1) imposing a duty on HMOs to exercise ordinary care in making medical decisions at the point of treatment that will affect the quality of that treatment, and (2) creating a cause of action against an HMO for harm that results from its breach of this duty. *See supra*, Part I. Health-care regulation of this sort is within "the historic police powers of the State." *See De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997); *see also N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) (noting that "general health care regulation . . . historically has been a matter of local concern").

The localized nature of health care regulation substantially raises the bar for a federal statute to preempt state law in this area. The

Court has "never assumed lightly that Congress has derogated state regulation, but instead [has] addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law." *Travelers*, 514 U.S., at 654. And, "where federal law is said to bar state action in fields of traditional state regulation, . . . [the Court has] worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act *unless that was the clear and manifest purpose of Congress*." *Id.*, at 655 (internal quotation and citation omitted) (emphasis added); *see also Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).[6]

Consequently, "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdich*, 530 U.S. 211, 237 (2000).[7] Overcoming the presumption of no

6. Aetna contends that *Travelers*, *Dillingham*, and *De Buono* are inapposite because those cases concerned defensive preemption under ERISA §514(a) rather than complete preemption under §502(a). *See* Aetna Br., at 37-40. But there is no principled reason why these decisions' general description of the preemption threshold would apply to one form of preemption and not the other. Indeed, it would make little sense to require a more substantial showing of congressional intent for §514(a) preemption—which merely provides an affirmative defense—than for §502(a) preemption—which displaces state law to such a degree that it transforms a civil action invoking that state law into a federal question. *See infra*, Part II.B. If anything, the more intrusive effect occasioned on state law by §502(a) complete preemption logically demands a greater showing of congressional purpose.

7. CIGNA protests that this precedent does not suggest "the existence of some unspoken health-care exemption from §502(a)'s preemptive force." CIGNA Br., at 7. The *Amici* States do not urge such a *per se* rule. What is plain from the Court's precedent, however, is that any preemption of state health-care regulation must rest on a heightened

preemption and establishing the requisite clear and manifest congressional intent is a "considerable burden." *De Buono*, 520 U.S., at 814. Aetna and CIGNA have failed to meet that burden here. They have not shown that the Court's prior explications of Congress's preemption objective control the preemption question in this case. And they have not otherwise demonstrated that Congress clearly and manifestly intended to preempt state health regulation of this sort when HMOs incorporate medical decision-making into their coverage determinations that affects the quality of a patient's treatment.

B. Davila's and Calad's Claims Do Not Fall Within the Existing Contours of §502(a) Complete Preemption as Defined by the Court.

The Court has held that Congress intended ERISA §502(a) to completely preempt a state-law cause of action on only three occasions: *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). In both *Pilot Life* and *Metropolitan Life*, the Court held that §502(a) preempted state-law tort claims arising out of the improper processing of ERISA benefit claims in violation of a duty of good faith imposed generally on contracting parties. And in *Ingersoll-Rand*, the Court concluded that §502(a) preempted state-law tort claims designed to vindicate rights already expressly guaranteed by ERISA. Davila's and Calad's state-law claims do not fall within the contours of congressionally mandated preemption as it has been defined in these cases.

1. *Pilot Life*

In *Pilot Life*, the plaintiff-employee filed an action against the insurer/administrator of his employer's disability benefits plan

showing of "clear and manifest" congressional intent. *Pegram*, 530 U.S., at 237.

arising out of the insurer's "failure to provide benefits under the insurance policy." 481 U.S., at 43. The employee's complaint contained several state-law claims seeking compensatory and punitive damages, but the only claim at issue on appeal was the cause of action for "tortious breach of contract." *Id.*, at 48. This action was in the nature of a bad-faith claim—*i.e.*, "the breach of contract was 'attended by some intentional wrong, insult abuse, or gross negligence'" or was otherwise "'arbitrary.'" *Id.*, at 49, 50 (quoting *Am. Ry. Express Co. v. Bailey*, 107 So. 761, 763 (Miss.1926) and *Blue Cross & Blue Shield of Miss., Inc. v. Campbell*, 466 So. 2d 833, 842 (Miss. 1984)).

The dispute did not concern whether this claim could be removed to federal court; the employee had filed his suit as a diversity action in federal district court under 28 U.S.C. §1332. *Id.*, at 43-44. Rather, the sole issue before the Court was whether the insurer was entitled to summary judgment on the employee's "tortious breach of contract" claim based on the defense that the claim was preempted under ERISA §514(a)'s express preemption provision. *Id.*, at 48. In aid of its §514(a) preemption analysis, the Court noted that it should seek guidance in the object and policy of ERISA as a whole. *Id.*, at 51. And specifically, because the employee's "tortious breach of contract" claim sought "remedies for the improper processing of a claim for benefits under an ERISA-regulated plan," the Court felt compelled to examine Congress's intent in enacting a scheme of civil-enforcement remedies in ERISA §502(a). *Id.*, at 51-52.

The Court concluded that Congress intended the civil-enforcement provisions of §502(a) to be "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Id.*, at 52. In support of this conclusion, the Court reasoned that the detail and comprehensiveness of §502(a) reflected careful consideration by Congress of which remedies for improper "claims settlement" would

be allowed, and necessarily, which would not. *See id.*, at 52-54. The Court found confirmation of this intent in ERISA's legislative history—the Conference Report expressly invoked the complete preemption afforded by §301 of the Labor-Management Relations Act as a model for ERISA:

> "[W]ith respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the Title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." H.R. CONF. REP. NO. 93-1280, at 327 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 5107, *and quoted in Pilot Life*, 481 U.S., at 55.

This explicit reference to the LMRA was significant because §301 "displace[s] entirely any state cause of action 'for violation of contracts between an employer and a labor organization.' Any such suit is purely a creature of federal law . . . ." *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 23 (1983) (quoting Labor Management Relations Act §301(a), 29 U.S.C. §185(a)).

Therefore, *Pilot Life* held that Congress intended for §502(a) to displace state-law actions "asserting improper processing of claims under ERISA-regulated plans" with such force that they "be treated as federal questions." 481 U.S., at 56. A state-law claim for "tortious breach of contract" grounded in a general duty to contract in good faith was therefore completely preempted. *Id.*, at 49-51.

Pilot Life does not mandate complete preemption of Davila's and Calad's THCLA claims for two reasons. First, as discussed in Part I, Davila's and Calad's suits are not directed to the "improper

processing of benefits claims." That is, they do not seek redress for the denial of benefits or improper conduct in the processing of benefits claims. Rather, they seek a remedy for their HMOs' negligent exercise of medical judgment at the point of treatment that adversely affected the quality of their treatment and resulted in personal injury. Their malpractice actions are not transformed into "improper processing" claims simply because the HMOs made their negligent medical decisions in the course of evaluating coverage. *See Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1293 n.5 (CA11 2003) (holding that *Pilot Life* does not control preemption of "malpractice action" which is not "based solely upon the improper processing of a claim").

Second, *Pilot Life* is inapposite on its facts—it holds only that §502(a)'s comprehensive remedial scheme for claims under ERISA plans displaces state-law torts arising from a general duty to perform contracts in good faith. To be sure, in providing an array of remedies for breaching ERISA plan provisions, Congress may not have directly contemplated that the *manner* in which the plan was breached would also be redressable outside of ERISA. But that logic cannot be stretched to suggest that Congress therefore clearly and manifestly intended to displace state-law torts arising from a specific duty to exercise ordinary care in rendering medical judgments that affect treatment simply because an HMO has chosen to undertake that duty as a component of a plan that it markets to employers. Stated differently, in providing an exclusive set of remedies for claims arising from ERISA plans, there is no indication that Congress clearly and manifestly intended to create a liability shield for plan administrators by allowing them to take any activity traditionally subject to state regulation and distilling it into a contract term in the plan. *See Hook v. Morrison Milling*, 38 F.3d 776, 783 (CA5 1994) ("ERISA was not enacted to allow employers to control which laws or claims are preempted and those which are not. . . . [W]e find no authority for the proposition that a law or claim is

preempted merely because the employer crafts its ERISA plan in such a way that the plan is inconsistent with that law or claim.").

2. *Metropolitan Life*

Taylor also was a suit by an employee arising out of a denial of disability benefits by the insurer of his employer's benefits plan. 481 U.S., at 60-61. The employee's specific claims against the insurer were breach of the insurance contract for the denial of benefits and an apparent tort claim described by the court of appeals as "wrongful termination of benefits." *Taylor v. General Motors Corp.*, 763 F.2d 216, 217 (CA6 1985), *rev'd sub nom. Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Through these claims, the employee sought to recover "money contractually owed Plaintiff, compensation for mental anguish caused by breach of this contract, as well as immediate reimplementation [*sic*] of all benefits and insurance coverages Plaintiff is entitled to." *Metropolitan Life*, 481 U.S., at 61. The employee joined with these claims various tort claims against his employer for retaliatory discharge and failure to promote. *Id.* The employer and insurer removed the case to federal court, asserting that the benefits-related claims against the insurer were preempted by ERISA, and that the district court could exercise pendent jurisdiction over the claims against the employer. *Id.*

Relying on *Pilot Life*, the Court held that the district court did have removal jurisdiction over the employee's suit because the benefits-related claims were so completely preempted by ERISA §502(a) that they were "converted" into federal questions. *See id.*, at 62-67. While reviewing the discussion of the legislative history in *Pilot Life*, the Court also noted that Senator Williams, a sponsor of ERISA, emphasized that "suit[s] to recover benefits denied contrary to the terms of the plan" would be deemed federal questions in the same manner that LMRA §301 preempted actions for violations of labor contracts. *Id.*, at 66. This explicit legislative intent persuaded the Court to overcome its "reluctan[ce] to find that

extraordinary pre-emptive power" that overrides the well-pleaded complaint rule. *Id.*, at 65.

Therefore, the Court held that §502(a) entirely preempted a breach of contract claim to recover plan benefits and, as in *Pilot Life*, a tort claim apparently predicated on a general duty of good faith imposed on contracting parties—*i.e.*, not to terminate contractual benefits "wrongfully." *See Taylor*, 763 F.2d, at 217. For the same reasons that *Pilot Life* is inapposite, *see supra*, Part.II.A.1, *Metropolitan Life* does not control the preemption question in this case.

3. *Ingersoll-Rand*

In *Ingersoll-Rand*, the employee sued his employer for the state-law tort of wrongful discharge, claiming that his employer terminated his employment to avoid making contributions to his ERISA-regulated pension fund. 498 U.S., at 135-36. As in *Pilot Life*, the issue presented was not removal jurisdiction, but whether the employer was entitled to summary judgment based on its defense of ERISA preemption. *See id.*, at 136. The Court initially addressed and determined that the wrongful discharge claim was expressly preempted under ERISA §514(a). *Id.*, at 138-142. In the alternative, however, the Court also examined whether this claim was impliedly preempted because of the complete preemptive force of §502(a)'s civil-enforcement scheme. *Id.*, at 142-45.

The Court began its §502(a) analysis by noting that the employee's wrongful discharge claim "falls squarely within the ambit of ERISA §510." *Id.*, at 142. That section provides in pertinent part:

> "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . *or for the purpose of interfering with the attainment of*

> *any right to which such participant may become entitled* under the plan . . . ." *Id.*, at 142-43 (quoting 29 U.S.C. §1140).

Thus, §510 prohibited precisely the sort of conduct complained of in the employee's wrongful discharge claim.

The employee in turn had a direct means to enforce §510's prohibition against interfering with the attainment of plan benefits—the enforcement provisions in §502(a). Specifically, the employee had the right under §502(a)(3) to file an action to enjoin violations of §510 or to obtain "other appropriate equitable relief" to redress the §510 violations. *Id.*, at 143 (quoting 29 U.S.C. §1132(a)(3)). "Unquestionably, the Texas cause of action [in *Ingersoll-Rand*] purports to provide a remedy for the violation of a right expressly guaranteed by §510 and exclusively enforced by §502(a)." *Id.*, at 145. For these reasons, the Court held, "[w]hen it is clear or may fairly be assumed that the activities which a State purports to regulate are protected by §510 of ERISA, due regard for the federal enactment requires that state jurisdiction must yield." *Id.* (internal quotations and citation omitted).

By contrast, the right to be free from negligent medical decisions that adversely affect treatment is not guaranteed or even addressed by §510 or any other provision of ERISA. Thus, §502(a)'s remedies to redress ERISA violations are not implicated by Davila's and Calad's suits, and therefore, *Ingersoll-Rand*'s rationale for complete preemption does not apply.

C. Aetna and CIGNA Have Not Otherwise Shown That Congress Clearly and Manifestly Intended to Preempt State Health-Care Liability Claims.

Not only have Aetna and CIGNA failed to demonstrate controlling support in the Court's previous §502(a) complete-preemption decisions, but they have not otherwise shown that Congress clearly and manifestly intended to preempt state health-

care regulation of this sort when HMOs undertake medical decision-making in the course of coverage determinations that affects the quality of patients' treatment.

The language, structure, and legislative history of ERISA are devoid of any evidence that preempting state health-care law was an element of the congressional design. The Court has observed that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S., at 661. And, in explaining that the indirect costs of state regulation alone do not constitute an impermissible intrusion into ERISA's exclusive sphere, the Court pointedly noted, "if ERISA were concerned with any state action—*such as medical care quality standards* . . .—that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach." *Dillingham Constr.*, 519 U.S., at 329 (emphasis added). Neither Aetna nor CIGNA has rebutted this assessment of ERISA's preemptive scope as it relates to health-care regulation.

Instead, Aetna's and CIGNA's principal contention is that, "at bottom," Davila and Calad complain only that they were denied coverage under their respective health plans, notwithstanding the medical judgment attending the coverage decision or its effect on the treatment delivered. *See* Aetna Br., at 26-28; CIGNA Br., at 25-31. But the Court has already rejected this characterization in *Pegram* when it noted that "medical necessity determinations" are in fact "mixed eligibility and treatment decisions." *See* 530 U.S., at 229-30. This more accurate description of "medical necessity" determinations reverberates in the preemption analysis in three ways:

- It removes such determinations from the category of "pure eligibility" decisions that are indisputably preempted by §502(a).

- As the Court noted, it defeats any suggestion that Congress clearly and manifestly intended that ERISA's fiduciary provisions preempt state-law regulation targeting such determinations. *See id.*, at 231 (expressing "doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature"), 232 (noting that "it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature").
- Finally, the Court's decision that ERISA's fiduciary provisions did not extend to mixed eligibility decisions was explicitly predicated in part on its recognition that state malpractice law already addressed claims targeting these determinations. *See id.*, at 235-37 (observing that an ERISA fiduciary action covering mixed eligibility decisions would unnecessarily federalize existing state malpractice actions against HMOs).

Aetna's and CIGNA's response to *Pegram* is twofold. First, they suggest that *Pegram*'s analysis should be limited to physician-owned HMOs and not extended to third-party HMOs that contract with a network of treating physicians. *See* Aetna Br., at 29-37; CIGNA Br., at 33-40. But as discussed in Part I, the Court in *Pegram* dispelled any notion that its assessment of mixed eligibility and treatment decisions was so confined. *See supra*, Part I.A.1; *see also Pegram*, 530 U.S., at 228-29. And, although Aetna and CIGNA may not have employed Davila's and Calad's treating physicians, they made "when-and-how" decisions in determining coverage that substantially directed the treatment given, with injurious results. *See supra*, Part I.A.2.

Aetna and CIGNA also attempt to deflect *Pegram* by asserting that the question whether Congress intended mixed eligibility and treatment decisions to be redressed through ERISA fiduciary claims is not dispositive of the preemption analysis. Aetna Br., at 35-37;

CIGNA Br., at 33; *see also* U.S. Br., at 26-27. In other words, while ERISA's remedies for breach of fiduciary duty (§502(a)(2) & (3)) do not redress claims for negligent mixed eligibility/treatment decisions under *Pegram*, state-law claims directed at the same wrongful conduct nonetheless remain completely preempted by as a result of §502(a)'s exclusive scheme. The result is to consign such claims to a "no-man's land" in which neither a federal or state remedy is available.

This conception of preemption necessarily fails because it is unsupported by any clear and manifest congressional purpose. Aetna and CIGNA have not directed the Court to any evidence that, in providing an exclusive remedial scheme to redress improper plan administration, Congress also clearly intended:

(1) to create a safe harbor from state health-care standards and substantive liability for HMOs that make negligent medical-necessity determinations adversely affecting the quality of treatment, so long as the negligence occurs in the course of a coverage decision; and

(2) at the same time, to exclude medical-necessity determinations from ERISA's fiduciary obligations and otherwise provide no relief for personal injuries proximately caused by negligent determinations.

In the absence of any positive indications of such intent, the Court has been rightly reluctant to interpret ERISA to effect preemption under these circumstances. *See Dillingham Constr.*, 519 U.S., at 330 (noting that "pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be unsettling") (internal quotation and citation omitted).

For these reasons, substantial doubts have been raised as to whether Congress intended §502(a)'s preemptive effect to reach state-law malpractice claims arising from HMO's negligent medical-necessity determinations. For example, Judge Becker lamented the

"ERISA preemption nightmare" occasioned by the analysis urged by Aetna and CIGNA here. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 464 (CA3 2003) (Becker, J., concurring). Under that interpretation, "ERISA *de facto* places the HMO in control of the treatment a participant receives, yet it preempts any state-law medical malpractice claim against that HMO and provides that the participant can recover no compensatory, punitive, or wrongful death damages regardless of its malfeasance." *Id.* Addressing whether this regime squared with congressional intent, Judge Becker commented:

> "[I]t is unlikely that Congress intentionally created this so-called, 'regulatory vacuum,' in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute. The more likely explanation is that Congress merely intended to create minimum safeguards to protect the financial integrity of welfare benefit plans while stopping short of federalizing the entire remedial regime, especially in light of what was a workable state-law remedial system." *Id.*, at 467.

If it is "unlikely" that Congress intended the "regulatory vacuum" generated by Aetna's and CIGNA's analysis, then there is no "clear and manifest purpose" to support complete preemption in this area. *See Pegram*, 530 U.S., at 237.

Likewise, the Second Circuit has observed that, in devising §502(a)'s civil-enforcement scheme, Congress did not anticipate the widespread use of prospective utilization review to make benefit-eligibility determinations at the point of treatment. *Cicio v. Does*, 321 F.3d 83, 98-99 (CA2 2003). "Prospective utilization review blurs boundaries between the traditionally distinct sphere of professional dominance and autonomy of the medical profession on the one hand, and the managerial domain on the other. As such, *it represents a development apparently unforeseen at the time of ERISA's enactment.*" *Id.*, at 98 (internal citations and quotations

omitted) (emphasis added). Thus, in selecting remedies to redress improper plan administration, there is no indication that Congress contemplated that plan administrators would be making pre-treatment medical judgments—traditionally subject to state-law standards—with "dispositive consequences for the course of treatment that a patient ultimately follows." *See id.*, at 98-99. Again, in the absence of "clear and manifest" congressional intent in this regard, there is no complete preemption. *See Pegram*, 530 U.S., at 237.

CONCLUSION

The *Amici* States urge the Court to affirm the judgment of the Fifth Circuit Court of Appeals.

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In the Supreme Court of the United States

AETNA HEALTH INC. et al., *Petitioners,*

v.

JUAN DAVILA, *Respondent.*

CIGNA HEALTHCARE OF TEXAS, *Petitioner,*

v.

RUBY R. CALAD, *Respondent.*

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, TEXAS MEDICAL ASSOCIATION AND AMERICAN PSYCHIATRIC ASSOCIATION IN SUPPORT OF RESPONDENTS

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29 U.S.C. § 1001 *et seq.* ..... *passim*

Tex. Civ. Prac. & Rem. Code § 88.001 *et seq.* (Vernon's 2003) ..... *passim*

Other Authorities:

K. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 Wake Forest L. Rev. 927 (1996) 22

R.G. Roetzheim et al., *Effects of Health Insurance and Race on Colorectal Cancer Treatment and Outcomes*, 90 Am. J. Pub. Health 1746 (2000) 11

M.K. Wynia et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?*, Health Affairs, Jul.-Aug. 2003, at 190 11

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INTEREST OF *AMICI CURIAE*

With the consent of the parties, reflected in letters on file with the Clerk of the Court, the American Medical Association ("AMA"), Texas Medical Association ("TMA") and American Psychiatric Association ("APA") submit this brief as *amici curiae* in support of Respondents, Calad and Davila, pursuant to Rule 37 of this Court.[1]

The AMA, the largest nonprofit association of physicians and medical students in the United States, was founded in 1847 to promote the science and art of medicine and the betterment of public health. These remain its purposes today. It sponsors a vast array of educational, scientific, and public health programs. The AMA engages in advocacy on behalf of physicians and the patients they serve, including efforts to bring quality to managed care.

The TMA is a private, voluntary, nonprofit association of Texas physicians and medical students. The TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its maxim continues in the same direction: "Physicians Caring for Texans." Its more than 39,000 members practice in all fields of medical specialization.

The APA, with more than 40,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus* in many cases in this Court, including prior ERISA cases.

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amici* state that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amici* and their counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

In the present cases, *amici* are concerned that the result sought by Petitioner HMOs would insulate HMOs who make medical treatment decisions for patients who are participants and beneficiaries in ERISA group health plans from accountability for those decisions. Without such accountability, those patients will be more at risk of treatment decisions made for reasons other than what is best for the patient, and the quality of their medical care will be lessened.

This result can be avoided by focusing on the nature of Calad's and Davila's claims. Unlike the claims at issue in this Court's prior complete preemption decisions, Calad and Davila do not seek payment or reimbursement from an ERISA plan. Rather, they are patients suing HMOs who made medical treatment decisions; they allege that these treatment decisions caused them injury. This Court has never had to consider whether ERISA complete preemption would extend to such a suit. As *amici* will demonstrate, reference to this Court's complete preemption decisions under the Labor Management Relations Act ("LMRA") provides a means to resolve these issues. This resolution supports the result reached by the Court of Appeals for the Fifth Circuit and is consistent with the Court's prior complete preemption holdings under ERISA and the LMRA.

SUMMARY OF ARGUMENT

Respondents Calad and Davila were participants in group health plans sponsored by their respective employers. Each employer's plan was an "employee welfare benefit plan" subject to the Employee Retirement Income Security Act of 1974 (an "ERISA plan"). Each employer entered into a contract with a health maintenance organization ("HMO") to utilize a package of the HMO's services to provide benefits to the plan's participants.

Petitioners are the HMOs utilized by the ERISA plans to make medical benefits available to their participants and beneficiaries. Calad and Davila each sought diagnosis or treatment for a medical condition and, doing so, became a patient. The treating physician for each patient determined a course of treatment that was appropriate for the patient (extended hospitalization for Calad and a particular drug for Davila). Each HMO made a medical decision not to provide the treatment recommended by the treating physician, so each patient had a different course of treatment than prescribed by the treating physician (discharge for Calad and a different drug for Davila). Each patient alleged that his or her medical condition worsened because of the HMO's treatment decision.

Calad and Davila filed suit in State court against their respective HMOs, invoking the Texas Health Care Liability Act ("THCLA"), which provides that "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." Their suits were removed to Federal court, but remanded by the Fifth Circuit.

The HMOs ask this Court to reverse the Fifth Circuit's holding that these suits may proceed in State court. The HMOs argue that these patients' claims are barred by the "complete preemption" exception to the "well-pleaded complaint doctrine," which this Court has recognized under the Employee Retirement Income Security Act of 1974 ("ERISA"). The HMOs are not seeking mere application of the Court's prior ERISA complete preemption holdings. They seek to extend those holdings to deny any patient who is a participant in an ERISA plan the right to hold an HMO accountable for a treatment decision. The result that

the HMOs seek is beyond the scope of the complete preemption doctrine.

Amici support the holding of the Fifth Circuit and urge the Court to affirm it. They believe that expansion of ERISA preemption as advocated by the HMOs is inconsistent with the Court's preemption jurisprudence and would have the effect of depriving patients who are also ERISA plan participants of State law protections, solely because they are ERISA plan participants.

The nature of Calad's and Davila's claims is critical to analysis of the complete preemption issue. Once a person seeks medical diagnosis or treatment, that person is a patient. As a patient, that person is entitled to State law rights and protections available to patients.

The HMOs try to characterize Calad's and Davila's claims as ordinary "claims for plan benefits." They refuse to acknowledge the fundamental difference of these claims from those held subject to ERISA complete preemption in prior decisions of this Court. The HMOs deny Calad's and Davila's rights as patients, as if ERISA participant status strips them of those rights. Calad and Davila did not seek anything from an ERISA plan that could be provided under ERISA's remedial scheme. They were injured patients, alleging that the HMOs made treatment decisions that violated Texas law standards for such decisions. This has nothing to do with any payment or reimbursement from an ERISA plan, or relief available under ERISA's remedial scheme.

Prior holdings of this Court dealing with ERISA complete preemption do not address claims involving medical treatment decisions. Instead, those cases involved State law suits alleging improper processing of disability benefit claims, or a wrongful discharge claim based on termination to avoid paying pension benefits. They involved claims based on *participant* status. Here, the HMOs' decisions

affected Calad and Davila *as patients*: Calad was discharged from the hospital; Davila received a different drug than his doctor prescribed.

This Court has repeatedly cautioned against expansive Federal preemption of State law. In recent terms, the Court has, in the context of ERISA's statutory preemption provision, discussed a presumption against preemption of the State's exercise of its "traditional police powers" and appeared skeptical of Congressional intent to federalize medical negligence law through ERISA. The bounds of ERISA complete preemption doctrine can best be determined by referring to cases construing the bounds of that doctrine vis-à-vis the LMRA, an act whose preemptive effect has served as the "model" for the Court's ERISA preemption analysis.

LMRA complete preemption jurisprudence has always recognized limits on such preemption. Under LMRA § 301, State law claims that are founded on rights or duties established by a collective bargaining agreement, or that substantially depend on the interpretation or analysis of that agreement, are preempted. However, State law claims are not preempted if the rights protected by the State law exist independently of the labor agreement, and the State law claim can be resolved without interpreting the labor agreement.

Applying these principles here, the complete preemption rule established by the Court's prior decisions should be clarified so that State law claims are not preempted if a State law claim: (1) does not seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA; and (2) is independent of and can be adjudicated without analysis or interpretation of the ERISA plan. Applied to the present cases, the rule *Amici* suggest would confirm that the remand of Calad's and Davila's suits to State court was appropriate.

This result is appropriate and correct because it provides a symmetrical application of the complete preemption exception under ERISA and the LMRA, honors the Court's traditional restraint in the preemption of State police powers, and provides a clear rule for application by the lower Federal courts. It does not preclude any arguments that the State law is preempted under ERISA § 514, as these may be raised, along with any other defenses, on remand.

ARGUMENT

I. Calad's and Davila's Claims under State Law Are Not Claims for ERISA Plan Benefits.

Respondent Ruby Calad, the spouse of an employee of The Ryland Group-Ryland Homes, was covered under a group health plan established and maintained by Ryland. Calad Compl. ¶ 17. Respondent Juan Davila, an employee of Monitronics, was covered under a group health plan established and maintained by Monitronics. Davila Compl. ¶ 11.

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, each Respondent's employer's group health plan is an "employee welfare benefit plan" subject to ERISA (an "ERISA plan"). 29 U.S.C. §§ 1002(1), 1003(a). Respondent Calad is a "beneficiary" under ERISA and Respondent Davila is a "participant."[2] Calad's employer utilized an HMO arrangement offered by Cigna to provide medical benefits to participants and beneficiaries of its ERISA plan, and Davila's

[2] 29 U.S.C. §§ 1002(8), 1002(7). There is no difference between the terms "participant" and "beneficiary" for purposes of this analysis, so Calad and Davila are both described hereinafter as "participants" in their respective ERISA plans.

employer utilized an HMO arrangement offered by Aetna for the same purpose.

In 1999, Calad had a hysterectomy with rectal, bladder, and vaginal repair. Although the physician performing the surgery recommended a longer stay, Cigna's hospital discharge nurse decided that a one-day hospital stay was sufficient. Calad suffered complications that she attributes to her early release, received emergency room care and continued to suffer from these complications. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002) ("*Roark*"); Calad Compl. ¶¶ 3-4.

Davila is a post-polio patient who suffers from diabetes and arthritis. In 2000, his primary care physician prescribed Vioxx for Davila's arthritis pain. Aetna required Davila to try two alternative drugs it considered appropriate for pain; only if he suffered a detrimental reaction to the medications or failed to improve could he obtain Vioxx. The first drug prescribed by Aetna was Naprosyn. After three weeks on it, Davila was rushed to the emergency room suffering from bleeding ulcers, which caused a near heart attack. He received seven units of blood and was in critical care for five days. As a result, he cannot take any pain medication that would be absorbed through the stomach. *Roark*, 307 F.3d at 303. Davila Compl. ¶¶ 12-15.

Each Respondent sued the respective HMO under the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code § 88.001 *et seq*. (Vernon's 2003). The THCLA provides that "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." Tex. Civ. Prac. & Rem. Code § 88.002(a). "Health care

treatment decision" is defined as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Tex. Civ. Prac. & Rem. Code § 88.001(5). "Ordinary care" is defined as "that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances [and in] the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, 'ordinary care' means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances." Tex. Civ. Prac. & Rem. Code § 88.001(10).

Calad's suit alleged that Cigna had provided medical services to her and, in doing so, violated the THCLA. Davila's suit alleged that Aetna influenced, controlled, participated in or made health care treatment decisions and, in doing so, violated the THCLA. Each sought relief for lost earnings, pecuniary loss, physical pain and mental anguish, and specifically disclaimed "reimbursement for treatment, medical procedures, or hospitalization" and "recover[y] for denial of any benefits." Calad Compl. ¶¶ 29, 33-34; Davila Compl. ¶¶ 17-24. When the HMOs removed the cases to Federal court, they were only at the pleading stage, so no facts have been adduced.

At the time they sought medical diagnosis or care, Calad and Davila were participants in ERISA plans. Completely independent of ERISA, though, when a participant seeks and receives medical diagnosis or care, that person has another status: that of a patient. As a patient, a person has relationships with those who provide medical care or

diagnosis. The patient is protected in these relationships. Sources of this protection include self-regulation by professional associations such as *amici*, and the accountability under State law of those who provide medical care or diagnosis.

When a participant becomes a patient, ERISA continues to regulate the "participant" relationship, but the new "patient" relationship is regulated from other sources. ERISA does not protect patients from negligent diagnosis or treatment,[3] but nothing in ERISA or its legislative history suggests that participants who become patients are not to be protected from negligent diagnosis or treatment.

> [N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . .

N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995) (citations omitted) ("*Travelers*").

> We find nothing in the legislative history suggesting that [ERISA] § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants.

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 357 (3rd Cir. 1995).

The rights of patients under State law are separate and distinct from the rights of ERISA plan participants under ERISA. The THCLA is a statute that regulates the relationship between patients and those who make health care treatment decisions for them.

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[3] *Cf. Thompson v. GenCare Health Sys., Inc.*, 49 F. Supp. 2d 1145, 1147 (E.D. Mo. 1999), *aff'd*, 202 F.3d 1072 (8th Cir. 2000).

Calad's treating physician prescribed a course of treatment that included more time in the hospital. Cigna determined that Calad was not hemorrhaging or exhibiting a fever or high blood pressure and would have to leave the hospital or pay approximately $1,500 per day to stay. As a result, Calad's course of treatment changed: she was discharged from the hospital.

Davila's treating physician prescribed a course of treatment that included the drug Vioxx. A formulary prepared by Aetna required Davila to try two other drugs in a "step program" before he could receive Vioxx, unless he could demonstrate "contraindication, intolerance, [or] allergy" to the other drugs. Out of fifteen possible pain-relieving drugs in its formulary, Davila received a prescription for Naprosyn. Davila Compl. ¶¶ 13-15; Aetna Br. at 9. As a result, Davila's course of treatment changed: he received a prescription for Naprosyn instead of Vioxx.

The actions of each HMO satisfy the THCLA's definition of a "health care treatment decision," that is, "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Tex. Civ. Prac. & Rem. Code § 88.002(a)(5). Calad and Davila each allege serious medical consequences as a result of the HMO health care treatment decisions.

Against common sense and the plain allegations in the Complaints, the HMOs disingenuously argue that they do not make health care treatment decisions. Aetna Br. at 6-7, 14-15, 26-27; Cigna Br. at 37. But there can be no question that each HMO made a decision involving discretionary consideration of medical factors which affected the quality of care or treatment received by Calad and Davila. Cigna's nurse (or someone who instructed the nurse) had to determine that Calad was not hemorrhaging,

feverish or exhibiting high blood pressure and that the absence of such symptoms justified denial of continued hospitalization. Someone at Aetna had to determine that Davila should take Naprosyn, out of fifteen permitted drugs, for his pain.[4] These decisions are "health care treatment decisions" within the THCLA definition and within any plain-meaning sense of those words.[5]

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[4] While Cigna and Aetna claim that they are not engaged in making medical decisions, each of these companies employ physicians and nurses as medical directors and engage in extensive "utilization review." On its web site at http://www.cigna.com/general/careers/featured (visited Jan. 20, 2004), Cigna provides the following job description for the position of a nurse to act as a Case Manager: "As a case manager with CIGNA HealthCare, you'll apply your professional skills and expertise in the assessment, planning, implementation, and coordination of necessary health care services for selected CIGNA members." At that same site, Cigna describes its nurse Patient Care Coordinator position as follows: "[Y]ou'll conduct daily concurrent reviews for all assigned admissions and participate in the care, *treatment* and discharge planning for members in an inpatient setting." (Emphasis added).

[5] The HMOs callously suggest that if they deny care, the patient should simply pay for it out-of-pocket and then seek reimbursement. As a practical matter, most people do not have the financial resources to do this; they go without care and suffer the consequences. This is well documented. *See, e.g.*, M.K. Wynia et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?*, Health Affairs, Jul.-Aug. 2003, at 190 (almost one in three physicians surveyed reported not offering useful but uncovered services to their patients, and the trend seems to be growing); R.G. Roetzheim et al., *Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes*, 90 Am. J. Pub. Health 1746 (2000) (patients with colorectal cancer who were uninsured or insured by Medicaid or commercial HMOs had higher mortality rates than patients with commercial fee-for-service insurance); *Insuring America's Health: Principles and*

(continued...)

Calad's and Davila's Complaints each set out all necessary elements of a claim against an HMO under the THCLA. They allege, particularly in Davila's claim against Aetna, that the HMO affirmatively provided medical care and was not a passive administrator. Nothing in either Complaint seeks to recover benefits due under the terms of the ERISA plan, to enforce rights under the terms of the ERISA plan, or to clarify rights to future benefits under the terms of the ERISA plan. Nothing in either Complaint seeks to enforce any substantive provision of ERISA. Their claims are the claims of injured patients seeking accountability for health care treatment decisions, not the claims of plan participants seeking remedies under ERISA. Such claims are not subject to ERISA complete preemption under this Court's prior holdings.

II. The Court's Previous ERISA Complete Preemption Decisions Do Not Address Claims Like Calad's and Davila's, Which Seek Neither Benefits under an ERISA Plan nor Enforcement of a Substantive Provision of ERISA.

The Court has dealt with the "complete preemption" exception under ERISA to the well-pleaded complaint doctrine in five cases. In *Franchise Tax Bd. of Cal. v.*

(...continued)
Recommendations, report, *available at* http://www.iom.edu/report, (visited Jan. 21, 2004) (underinsured and uninsured individuals are lower income and are less likely to pay out-of-pocket for services; instead, they go without care). *Amici* recognize that the beneficiary in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), did incur the expense of the HMO-denied treatment, but in order to do so, she withdrew all funds from her unemployed husband's IRA and charged her mother-in-law's and her own credit cards to their limits.

Construction Laborers Vacation Trust for S. Cal., 463 U.S. 1, 7-12 (1983) ("*Franchise Tax Board*"), the Court first considered whether "ERISA, like § 301 [of the Labor Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 141 *et seq.*], was meant to create a body of federal common law, and that 'any state court action which would require the interpretation or application of ERISA to a plan document "arises under" the laws of the United States.'" 463 U.S. at 24. Justice Brennan's opinion suggested such an extension of the LMRA doctrine to ERISA:

> ERISA contains provisions creating a series of express causes of action in favor of participants, beneficiaries, and fiduciaries of ERISA-covered plans, as well as the Secretary of Labor. § 502(a), 29 U.S.C. § 1132(a). It may be that, as with § 301 as interpreted in *Avco*, any state action *coming within the scope of § 502(a) of ERISA* would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law.

Id. (emphasis added).

However, the extension did not occur in *Franchise Tax Board* because "[n]either of appellant's claims in this case comes within the scope of one of ERISA's causes of action." *Id.* While the state law claims may have involved ERISA plans, they did not come within the scope of § 502(a)'s causes of action. In its subsequent decisions, the Court dealt with State law claims which did come within the scope of the § 502(a) causes of action.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ("*Pilot Life*"), a participant challenged the way his claims for disability benefits under an ERISA plan were handled. He made no claim under ERISA, but sued under three State law causes of action, seeking various general, punitive and exemplary damages. *Pilot Life*, 481 U.S. at 43-44. The Court, in a unanimous opinion by Justice O'Connor, held

that the State law claims fell under ERISA's statutory preemption provision, § 514(a), and then went on to consider whether they were "saved" under the "saving clause" in § 514(a)(2). *Pilot Life*, 481 U.S. at 47-48. That analysis, though, "must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA 502(a), 29 U.S.C. § 1132(a)." *Id.* at 52. The Court continued:

> The Solicitor General, for the United States as *amicus curiae*, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of 502(a) would pose an obstacle to the purposes and objectives of Congress . . . We agree.

Id. (emphasis added) (internal citations omitted). The Court reviewed ERISA legislative history:

> The Conference Report on ERISA describing the civil enforcement provisions of 502(a) says:
>
> > "Under the conference agreement, civil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of fiduciary responsibility. . . . [W]ith respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. *All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947*." H.R.Conf.Rep. No. 93-1280, p. 327 (1974), U.S.Code Cong. & Admin.News 1974, pp. 4639, 5107.

Id. at 55 (italics in original) (underline emphasis added). The Court next discussed the scope of preemption under the LMRA:

> [T]he broad pre-emptive effect of § 301 was first analyzed in *Teamsters v. Lucas Flour Co.*, 369 U.S. 95 (1962). In *Lucas Flour* the Court found that "[t]he dimensions of § 301 require the conclusion that substantive principles of federal labor law must be paramount *in the area covered by the statute*." *Id.*, at 103.

Id. (emphasis added). The Court concluded:

> Congress' specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants *asserting improper processing of claims under ERISA-regulated plans* be treated as federal questions governed by § 502(a).

Id. at 56 (emphasis added).

On the same day, the Court decided *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (*"Taylor"*). *Taylor* also involved a challenge to claims processing under an ERISA plan, but, unlike *Pilot Life*, was brought in State court. *Taylor*, 481 U.S. at 60-61. In another unanimous opinion by Justice O'Connor, the Court held that the State law contract and tort claims seeking benefits owed plus additional damages were preempted, citing *Pilot Life* and ERISA § 514(a). *Id.* at 62. It went on to consider whether the State law claims "were also displaced by ERISA's civil enforcement provision, § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to the extent that complaints filed in state courts purporting to plead such state common law causes of action are removable to federal court under 28 U.S.C. § 1441(b)." *Id.* at 60. In deciding that they were, the Court observed that the State lawsuit, *"as a suit by a*

beneficiary to recover benefits from a covered plan . . . falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63 (emphasis added). Discussing the same legislative history relied upon in *Pilot Life*, Justice O'Connor described it as a "clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of the LMRA." *Id.* at 66 (emphasis added).

Under *Pilot Life* and *Taylor*, certain State law actions by participants and beneficiaries are removable to Federal court and are treated as Federal questions governed by § 502(a). The class of actions subject to this "complete preemption" is described in *Pilot Life* as "suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans," *Pilot Life*, 481 U.S. at 56, and in *Taylor* as "§ 502(a)(1)(B) suits brought by participants or beneficiaries" (*i.e.*, suits to recover benefits due under the terms of the ERISA plan, to enforce rights under the terms of the ERISA plan, or to clarify rights to future benefits under the terms of the ERISA plan). *Taylor*, 481 U.S. at 66.

Neither Complaint in the cases before the Court can be accurately characterized in those terms. The preempted class of cases is thus defined by the class of cases that may be brought under § 502(a), which is logical, as "[§ 502(a)] does not purport to reach every question relating to plans covered by ERISA." *Franchise Tax Board*, 463 U.S. at 25.

The Court next addressed these issues in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) ("*Ingersoll-Rand*"). At issue there was a State wrongful discharge action alleging that the primary reason for firing the employee was "to deprive him of pension benefits under an ERISA

plan." *Ingersoll-Rand*, 498 U.S. at 136. The Court found that the suit was "explicitly preempted" under ERISA § 514(a), *id.* at 138-42, and then determined that the claim was "implicitly preempted," "because it conflict[ed] directly with an ERISA cause of action." *Id.* at 142. Specifically, the Court held: ERISA § 510 "protects plan participants from termination motivated by an employer's desire to prevent a pension from vesting;" ERISA § 502(a) is "the exclusive remedy for rights guaranteed under ERISA, including those provided by § 510;" *id.* at 143-44, and "the exclusive remedy provided by § 502(a) is precisely the kind of 'special featur[e]' that 'warrant[s] pre-emption' in this case." *Id.* at 144. The Court concluded:

> [T]he Texas cause of action purports to provide a remedy for the violation of a right expressly guaranteed by § 510 and exclusively enforced by § 502(a). Accordingly we hold that "[w]hen it is clear or may fairly be assumed that the activities which a State purports to regulate are protected" by § 510 of ERISA, "due regard for the federal enactment requires that state jurisdiction must yield."[6]

Id. at 145. Thus, for there to be "implicit preemption" of a State law claim under *Ingersoll-Rand*, the claim must be for violation of ERISA § 510 (or, it would seem, some other substantive provision of ERISA) which is "exclusively enforced" under § 502(a). The Complaints in the cases now before the Court cannot be characterized as making such a claim.

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[6] This language is drawn from footnote 8 of the Court's opinion in *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399 (1988), an LMRA preemption case. In that footnote, the Court discussed Federal labor-law principles other than LMRA § 301 that may preempt State law. 486 U.S. at 408-09 & n.8.

Finally, complete preemption was discussed in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) ("*Moran*"). There, the Court held both that a State-mandated independent review of HMO "medical necessity" decisions was "saved" from § 514 preemption as insurance law, *Moran*, 536 U.S. at 365-75, and that the independent review procedure was not completely preempted either, because it "provides no new cause of action under state law and authorizes no new form of ultimate relief." It "does not enlarge the claim beyond the benefits available in any action brought under § [502(a)]," and functioned more like a "rule of decision" which would then be enforced in a § 502(a) suit. *Id.* at 379-80.

Moran's holding does not add to the types of claims completely preempted under *Pilot Life*, *Taylor*, and *Ingersoll-Rand*. Indeed, the Court declined "to turn dictum into holding by declaring that the state insurance regulation . . . is preempted." *Moran*, 536 U.S. at 377. Justice Souter noted that, after *Pilot Life*, "we have found only one other state law to 'conflict' with [§ 502(a)] in providing a prohibited alternative remedy." *Id.* at 379. That case, of course, was *Ingersoll-Rand*, and the discussion of that decision in *Moran* provides a useful summary of the Court's ERISA complete preemption holdings:

> [In *Ingersoll-Rand*] we had no trouble finding that Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement; while state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under [§ 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal). Thus, *Ingersoll-Rand* fit within the category of state laws *Pilot Life* had held to be incompatible with ERISA's enforcement scheme; the law provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA.

Moran, 536 U.S. at 379.

Out of context, the last sentence just quoted from *Moran* might be read to suggest a broader holding in *Ingersoll-Rand* than was the case. Given the Court's focus in *Ingersoll-Rand* on the enforcement of § 510 through § 502(a), the statement "*Ingersoll-Rand* fit within the category of state laws *Pilot Life* had held to be incompatible with ERISA's enforcement scheme; the law provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA" appears limited to judicial remedies provided by ERISA *for* violations of ERISA.

In summary, a State law claim will be completely preempted if it is a claim for benefits described in § 502(a)(1)(B), *see Pilot Life*, 481 U.S. at 57; *Taylor*, 481 U.S. at 62-63, or if it seeks to enforce a right protected by ERISA and enforced through § 502(a). *See Ingersoll-Rand*, 498 U.S. at 145. In *Pilot Life* and *Taylor*, plan participants were seeking disability benefits under State law, while ERISA § 502(a)(1)(B) provided a specific cause of action to seek such benefits. In *Ingersoll-Rand*, the former participant's State lawsuit was premised on the employer's desire not to pay pension benefits, while under ERISA § 510, enforced through § 502(a)(3), "the relief requested . . . is well within the power of federal courts to provide." *Ingersoll-Rand*, 498 U.S. at 145. In *Moran*, the State independent review mechanism was held to be ancillary to § 502(a)(1)(B) as the means to seek reimbursement for health care expenses incurred by the participant. *See Moran*, 536 U.S. at 380.

In each of the cases in which complete preemption was found, the challenged actions raised a question that could be specifically addressed under § 502(a): Were disability

benefits due to Dedeaux and Taylor under the terms of the plan? Was McClendon discharged for the purpose of interfering with the attainment of any right to which he might become entitled under the plan? Similarly, in *Moran*: could the State independent review procedure be used in determining whether reimbursement of her medical expenses was due to Moran under the terms of the plan?

By contrast, the questions raised by Calad and Davila are not addressed by ERISA: Was the decision that Calad did not have symptoms that required continued hospitalization made with the exercise of ordinary care? If not, was that failure the proximate cause of harm to her? Was the decision to prescribe Naprosyn for Davila's pain made with the exercise of ordinary care? If not, was that failure the proximate cause of harm to him?

Here, the HMOs' actions affect Calad and Davila as patients; neither received the course of treatment prescribed by his or her treating physician. This implicates the protections which Texas has created in the THCLA for patients who are injured by health care treatment decisions. Calad and Davila assert claims under the THCLA against the HMOs that are separate, distinct and independent from ERISA's causes of action, like the claims in *Franchise Tax Board*, neither of which "[came] within the scope of one of ERISA's causes of action." 463 U.S. at 24-25. The question the Court must resolve is whether, under the complete preemption exception to the well-pleaded complaint doctrine, they can bring these claims in State court (subject, of course, to any defenses, including ERISA § 514 defenses, raised by the HMOs).

The holdings in the Court's ERISA complete preemption cases do not answer this question. Calad's and Davila's State lawsuits do not seek payments, reimbursement or any other benefit from an ERISA plan. *Cf. Pilot Life*, 481 U.S. at 57; *Taylor*, 481 U.S. at 62-63. They do not seek

to enforce any statutory right under ERISA through § 502(a)(3). *Cf. Ingersoll-Rand*, 498 U.S. at 145. If we study the basis for the holdings articulated in these three opinions, we see that in each case the Court described complete preemption, with reference to ERISA's legislative history, e.g., as "modeled after § 301 of the LMRA." *Pilot Life*, 481 U.S. at 54; *see also Taylor*, 481 U.S. at 65-67 ("in like manner as § 301 of the LMRA"), and *Ingersoll-Rand*, 498 U.S. at 144-45 ("the parallel between § 502(a) and § 301 of the LMRA"). Therefore, any consideration of the scope of ERISA § 502 complete preemption should be made with reference to the scope of LMRA § 301 complete preemption.

III. This Court's LMRA § 301 Complete Preemption Jurisprudence Recognizes Limits on Preemption and Provides a Related Body of Precedent, Applicable to the Cases Before the Court.

The Court adopted the LMRA § 301 complete preemption exception to the well-pleaded complaint rule in *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), it then explained the scope of LMRA § 301 complete preemption in a series of cases beginning in 1985. The development of ERISA § 502 complete preemption occurred simultaneously with, and was intertwined with, these LMRA decisions.[7] This Court has heard more cases, presenting more issues, in connection with LMRA complete preemption than ERISA complete preemption. Heeding the Congressional intent that cases under ERISA § 502 "be regarded . . . in

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[7] *See Franchise Tax Board* (1983) (ERISA); *Lueck* (1985) (LMRA); *Pilot Life* (1987) (ERISA); *Taylor* (1987) (ERISA); *Hechler* (1987) (LMRA); *Caterpillar* (1987) (LMRA); *Lingle* (1988) (LMRA); *Rawson* (1990) (LMRA); *Ingersoll-Rand* (1990) (ERISA); *Livadas* (1994) (LMRA).

similar fashion" to those brought under LMRA § 301, we can turn to existing precedent of this Court under § 301 for guidance in the present cases.

LMRA § 301 complete preemption is based on the Supremacy Clause of Article VI of the Constitution. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985) ("*Lueck*"). Because Congress has never exercised the authority to occupy the entire field of labor legislation, the question of whether a State action is preempted is limited to Congressional intent. *Id.*[8] State law claims that are founded on rights or duties established by a collective bargaining agreement, or that substantially depend on the interpretation or analysis of a collective bargaining agreement, are preempted. *Lueck*, 471 U.S. at 213 (State tort of bad faith handling of disability benefit payments due under a labor contract is preempted by LMRA § 301; claim is "inextricably intertwined" with, and substantially dependent upon, interpretation of the labor contract);[9] *International Brotherhood of Electrical Workers, AFL-CIO, et al. v. Hechler*, 481 U.S. 851 (1987) (negligence claim against union preempted because claim depended on whether the union had contractually assumed a duty of care for its members, requiring the interpretation of the labor contract); *United Steelworkers of America, AFL-CIO v. Rawson*, 495 U.S. 362 (1990) (tort claim preempted where duty allegedly assumed by union did not exist outside of collective bargaining agreement).

[8] Accordingly, LMRA § 301 complete preemption is conflict preemption, not express or implied preemption. *See* K. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 Wake Forest L. Rev. 927, 955 (1996). *See also Lueck*, 471 U.S. at 208-09. *See generally Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372-73 (2000); *Hines v. Davidowitz*, 312 U.S. 52, 70 (1941).

[9] In addition, the Court found that if the claim at issue were not preempted, an employee would have the option of bypassing the grievance procedures and going to State court, thereby compromising the Federal right of the parties to choose arbitration as the means to resolve labor contract disputes. *Lueck*, 471 U.S. at 219-20; *see also Lingle*, 486 U.S. at 411 (same).

Complete preemption under § 301 of the LMRA addresses the need for a unified body of Federal law to govern the interpretation and enforcement of collective bargaining agreements. *Textile Workers Union of America v. Lincoln Mills of Alabama*, 353 U.S. 448, 456-57 (1957). Moreover, Congress intended, through § 301, to specifically enforce promises to arbitrate grievance disputes under collective bargaining agreements. *Id.* at 451; *see also Local 174, Teamsters v. Lucas Flour Co.*, 369 U.S. 95, 105 (1962) ("the basic policy of national labor legislation [is] to promote the arbitral process as a substitute for economic warfare"); *Avco*, 390 U.S. at 559 (§ 301 of the LMRA was "fashioned by Congress to place sanctions behind agreements to arbitrate grievance disputes").

Outside the scope of the rights and duties established by the collective bargaining agreement and interpretation of the collective bargaining agreement, the rationale for preemption is not present.

> But even under § 301 we have never intimated that any action merely relating to a contract within the coverage of § 301 arises exclusively under that section. For instance, a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract.

Franchise Tax Board, 463 U.S. at 25 & n.28 (citing *U.A.W. v. Russell*, 356 U.S. 634, 640-42 (1958)).

> [W]hile this sensible "acorn" of § 301 pre-emption recognized in *Lucas Flour* has sprouted modestly in more recent decisions of this Court . . . it has not yet become, nor may it, a . . . "mighty oak."

Livadas v. Bradshaw, 512 U.S. 107, 122 (1994) (citations omitted).

This Court has held that State law claims are *not* preempted if (1) the rights that the State law protects exist independently of the labor agreement, and (2) the State law claim can be resolved without interpreting the labor agreement. *Lueck*, 471 U.S. at 212 ("it would be inconsistent with congressional intent under [§ 301] to preempt state rules that proscribe conduct, or establish rights and obligations, independent of a labor contract").

In *Lingle v. Norge Division of Magic Chef, Inc.*, an employee's State court claim for retaliatory discharge for exercising rights under the Illinois Workers' Compensation Act was held not preempted by LMRA § 301, despite the fact that the collective bargaining agreement protected the employee from termination without "just cause." *Lingle*, 486 U.S. at 408-10. The Court reasoned that the plaintiff's claim rested on "purely factual questions pertain[ing] to the conduct of the employee and the conduct and motivation of the employer." *Id.* at 407. Because the elements of the State law retaliatory discharge claim did not turn on the meaning of any provision of the collective bargaining agreement, the claim was not preempted. *Id.* Even if resolution of the State law claim and a claim pursuant to the collective bargaining agreement would require addressing "precisely the same set of facts," there is no preemption as long as the State claim can be resolved without interpreting the agreement. *Id.* at 409-10; *see also Livadas*, 512 U.S. at 123-24 (the mere fact that a collective bargaining agreement would be consulted in the course of the State law litigation did not give rise to preemption).

Similarly, in *Caterpillar Inc. v. Williams*, employees brought claims that Caterpillar discharged them in violation of alleged individual employment agreements. 482 U.S. 386 (1987). Caterpillar argued that because the

employees were covered by a collective bargaining agreement at the time of their termination, their breach of contract claims were preempted by LMRA § 301. The Court disagreed, reasoning that while the employees *could have* brought suit under § 301, and had substantial rights under the collective bargaining agreement as bargaining unit members at the time of their termination, this did not give rise to preemption. *Id.* at 394-95. The Court found that their complaint did not "substantially depend" upon interpretation of the collective bargaining agreement. *Id.* at 394-95.

Most recently, in *Livadas*, the Court held that a State statute requiring employers to pay immediately all wages due to discharged employees, as applied to employees governed by a collective bargaining agreement, was not preempted by LMRA § 301, stating: "§ 301 cannot be read broadly to preempt nonnegotiable rights conferred on individual employees as a matter of state law" and "it is the legal character of a claim, as 'independent' of rights under the collective bargaining agreement . . . that decides whether a state cause of action may go forward." *Livadas*, 525 U.S. at 123-24 (internal citation omitted).[10]

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[10] Following this Court's precedent, numerous Federal circuit courts have refused to find LMRA § 301 complete preemption where the State law claims could be resolved independently of the collective bargaining agreement. *See, e.g.*, *Northwestern Ohio Administrators, Inc. v. Walcher & Fox, Inc.*, 270 F.3d 1018 (6th Cir. 2001) (claim that union fraudulently induced employer to sign project agreements not preempted); *Sprewell v. Golden State Warriors*, 266 F.3d 979 (9th Cir. 2001) (claims for intentional interference with contract and business relations not preempted to the extent based on California law and not collective bargaining agreement); *Pennsylvania Nurses Assoc. v. Pennsylvania State Education Assoc.*, 90 F.3d 797 (3d Cir. 1996) (breach of fiduciary duty and fraud claims were not preempted by § 301); *Trans Penn*

(continued...)

Significantly, in *Caterpillar*, the Court recognized that an "independent" State law claim could not be recharacterized as a Federal § 301 claim in order to give rise to preemption, merely because plaintiffs *could have* brought suit under § 301. *Caterpillar*, 482 U.S. at 394-95.

> Caterpillar impermissibly attempts to create the prerequisites to removal by ignoring the set of facts (*i.e.*, the individual employment contracts) presented by respondents, along with their legal characterization of those facts, and arguing that there are different facts respondents might have alleged that would have constituted a federal claim. In sum, Caterpillar does not seek to point out that the contract relied upon by respondents is in fact a collective agreement; rather it attempts to justify removal on the basis of facts not alleged in the complaint. The "artful pleading" doctrine cannot be invoked in such circumstances.

Id. at 396-97.

These well-established principles under LMRA § 301, allowing bargaining unit members to assert claims that arise independent of that status. Thus, the LMRA, the statute that Congress and this Court have identified as the "model" for ERISA § 502, instruct that the claims at issue are not subject to complete preemption under ERISA § 502.

Calad's and Davila's State law rights as patients are independent of the ERISA plan. When an HMO makes a health care treatment decision subject to the THCLA, that act has legal consequences separate and distinct from ERISA's remedial scheme.

(...continued)
Wax Corp. v. McCandless, 50 F.3d 217 (3d Cir. 1995) (claims for breach of individual employment agreements, fraud, and intentional infliction of emotional distress were not subject to § 301 preemption).

Each element of Calad's and Davila's THCLA claims can be determined without analysis or interpretation of the ERISA plans. First, there must be a "health care treatment decision," as defined in the statute. That decision must be made by a "health insurance carrier, health maintenance organization, or other managed care entity for a health care plan" (each term as defined in the statute) or an employee, agent, ostensible agent or certain representative (terms whose meanings can be determined under general law principles). There must be a failure to exercise "ordinary care" (as defined in the statute) in making the decision, and that failure must be the "proximate cause" of "harm" to the insured or enrollee. This is the stuff of ordinary tort litigation, overlaid with some specific statutory definitions, not analysis or interpretation of an ERISA plan.

The rights of Calad and Davila, as patients, under the THCLA can be preserved with a rule that interprets the scope of ERISA § 502 complete preemption to cover claims (1) to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or enforce any substantive provision of ERISA; or (2) which are not independent of or cannot be resolved without analysis or interpretation of the ERISA plan. *See Lingle*, 486 U.S. at 408-10. *Amici* urge the Court to do so.

This result leaves the Court's prior ERISA § 502 complete preemption holdings undisturbed. The claims in *Pilot Life, Taylor* and *Ingersoll-Rand* are covered by part (1) of the rule proposed above, while *Moran* demonstrates that there is no complete preemption of a State law claim that does not provide a new cause of action described in part (1). *Franchise Tax Board* continues to remind us that the scope of § 502(a), and thus its preemptive effect, is limited. The Court's prior holdings would continue to be precedent with respect to State law claims that seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or enforce any

substantive provision of ERISA. Part (2) of the rule urged by *amici* today would provide the next step of ERISA § 502 complete preemption analysis. It derives directly from *Lueck* and subsequent LMRA § 301 complete preemption cases, substituting the ERISA plan for the collective bargaining agreement. (The plan is to ERISA § 502 as the collective bargaining agreement is to LMRA § 301.) *Amici* believe that such a holding is appropriate for several reasons.

First, it would honor the Court's repeated admonitions that preemption of State law is to be undertaken carefully and narrowly in cases like this which involve a State's exercise of its "traditional police powers" for the health and safety of its citizens. *See English v. General Elec. Co.*, 496 U.S. 72, 79 (1977); *Maurer v. Hamilton*, 309 U.S. 598, 614 (1940); *see also Hillsborough County v. Automated Med. Labs.*, 471 U.S. 707, 715 (1985).

Second, it would adhere to the ERISA legislative history that ERISA § 502 be construed similarly to LMRA § 301. LMRA § 301 complete preemption applies to claims that: (1) are founded on rights or duties established by a collective bargaining agreement and enforced under § 301; or (2) substantially depend on the interpretation or analysis of a collective bargaining agreement. ERISA § 502 complete preemption would apply to State law claims that: (1) seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA; or (2) are not independent of or cannot be resolved without analysis or interpretation of an ERISA plan. The ERISA § 502(a) remedial scheme is preserved and kept exclusive for claims available under it, as the LMRA § 301 enforcement scheme is preserved and kept exclusive to enforce rights and duties under a collective bargaining contract. The interpretation of the ERISA plan, like the interpretation of the collective bargaining contract, is reserved as a matter of Federal law.

Such a holding would also be consistent with the Court's presumption against preemption, regardless of the source or type of preemption, expressed in *Travelers* with respect to State regulation of health care:

> Our past cases have recognized that the Supremacy Clause, U.S. Const., Art. VI, may entail pre-emption of state law either by express provision, by implication, or by a conflict between federal and state law. And yet, despite the variety of these opportunities for federal preeminence, we have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

Travelers, 514 U.S. at 654-55 (internal citations omitted).

In addition, it is also consistent with the Court's observation in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that "we have seen enough to know that ERISA was not enacted . . . to federalize malpractice litigation in the name of fiduciary duty or for any other reason." *Pegram*, 530 U.S. at 236. For ERISA, which does not even mention health care treatment standards, to preempt the remedies of a patient for negligent diagnosis or treatment because that patient is also an ERISA participant is at odds with the purpose of a statute intended to be remedial, and protective of employees' rights.

Finally, such a holding will provide useful guidance for lower Federal courts, which often hear complete preemption challenges to State law negligence, wrongful death or similar claims against an HMO that failed to provide a

particular course of treatment to a patient who was an ERISA plan participant. The holdings in these cases often turn on whether the court finds the HMO's decision to involve the "quality" of benefits provided (no complete preemption) or the "quantity" of benefits sought (complete preemption). However, this test invites judicial hair-splitting, causing courts to reach conflicting results under similar facts.[11]

CONCLUSION

For the foregoing reasons, *amici* urge the Court to recognize that when a State, in the course of its regulation of matters of health and safety, provides a cause of action like that available to injured patients under the THCLA, that cause of action will not be denied to patients who are also ERISA plan participants, if the State law claim (1) does not seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA, and (2) is independent of and can be adjudicated without analysis or interpretation of the ERISA plan. *Amici* believe that to do so provides a solution to the issues raised in the present cases which is harmonious with the Court's prior ERISA decisions, consistent with its related jurisprudence under the LMRA, and mindful of the limits the Court has repeatedly placed on the preemption of State law.

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[11] *Cf. Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999); *Hull v. Fallon*,188 F.3d 939 (8th Cir. 1999); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999).

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AETNA HEALTH INC.
Petitioner,
v.
JUAN DAVILA,
Respondent

CIGNA HEALTHCARE OF TEXAS, INC.
Petitioner,
v.
RUBY R. CALAD, ET AL.,
Respondent

On Writs of Certiorari To The United States Court of Appeals For the Fifth Circuit

BRIEF *AMICI CURIAE* OF AARP AND THE NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES IN SUPPORT OF RESPONDENTS

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No. 02-1845

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF *AMICI CURIAE* OF AARP IN SUPPORT OF PETITIONERS

BRIEF *AMICI CURIAE* OF AARP AND THE NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES

INTEREST OF *AMICI CURIAE*[1/]

AARP is a nonpartisan, nonprofit membership organization of over 35 million persons, age 50 or older, dedicated to addressing the needs and interests of older

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[1/] No counsel for any party authored any portion of this brief. No persons other than *amici curiae*, their members, or their counsel have made a monetary contribution to the preparation and submission of this brief. Petitioners and Respondents have consented to the filing of amicus briefs in support of either party and that consent has been filed with the Clerk of the Court.

Americans. AARP seeks through education, advocacy and service to enhance the quality of life for all by promoting independence, dignity, and purpose. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling costs without compromising quality.

As additional means to foster the economic security of older individuals, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits. Many employed and retired AARP members participate in health care plans sponsored by their employers. Participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans. 29 U.S.C. § 1001 *et seq.* However, ERISA, the statute that was designed to safeguard employee benefits, has been applied by many courts to deprive employees of rights and protections they would otherwise have under state health care and insurance laws simply because an employer sponsored health plan paid for their health care.[2/] Thus, as part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefits of ERISA's protections, AARP has participated as *amicus curiae* in numerous cases involving ERISA's preemption clause, and also filed an *amicus* brief in *Pegram v. Herdrich*, 530 U.S. 211 (2000)(whether claims that a health maintenance organization (HMO) limited care to save money and increase physician compensation could constitute a breach of ERISA's fiduciary duties).

The National Partnership for Women & Families is a national non-profit organization working to improve the lives

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[2/] Patricia Butler & Karl Polzer, Nat. Health Policy Forum, *Private Sector Health Coverage: Variation in consumer protections under ERISA and State Law* (1996).

of women and families through public advocacy, public education, and private partnerships. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership promotes equal opportunity for women, access to quality health care and policies that help women and men meet the competing demands of work and family. The National Partnership has a longstanding history of defending the interests of women in the workplace and working to ensure that women have access to the benefits they need to support themselves and their families. The National Partnership firmly believes that strong and enforceable patient protections are an essential component of ensuring access to quality health care. In support of this goal, the National Partnership has been a leading voice in promoting and defending meaningful patient protections for individuals in employer-sponsored health plans and public health programs.

SUMMARY OF ARGUMENT

ERISA does not preempt state law claims for damages allegedly caused by managed health care organizations' failure to exercise ordinary care in making medical decisions. The claims in both these cases arise out of the managed care entities exercising medical judgment. States have the power to regulate relationships between managed care entities and their enrollees, just as they do all other health care relationships, in order to protect the health and well being of the States' residents, to hold those that benefit from providing health care accountable for injuries they cause, and to provide a mechanism to compensate those who are injured. Holding managed care entities responsible will not undermine employer based health care coverage, or make health care inaccessible. Instead, permitting state courts to determine liability for negligent medical judgment will maintain the balance of equities between managed health care entities and patients, as well as maintain the balance of federalism between federal and state laws. For all of these reasons, the Court should affirm the Fifth Circuit's decision that ERISA does not preempt the plaintiffs' claims under the Texas Health Care Liability Act (THCLA).

ARGUMENT

I. ERISA DOES NOT PREEMPT STATE LAWS REGULATING THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING MEDICAL JUDGMENTS

A. The Proceedings Below

The plaintiffs in these consolidated cases filed claims in state court under the state law known as the THCLA.[3/] The THCLA merely codifies the long standing ability of Texas, as in other States, to protect the health and well being of its residents by establishing that those who exercise medical judgment affecting another person owe a duty of ordinary care to that person. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., (Travelers)* 514 U.S. 645, 661 (1995) (health care is an area of traditional state regulation).

Ms. Calad sued her HMO, CIGNA, in state court under THCLA after sustaining personal injuries following a hysterectomy. She alleged that CIGNA failed to exercise ordinary care when CIGNA's hospital discharge nurse determined that Ms. Calad should be discharged after a one day

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[3/] The statute provides:

> A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a). The THCLA defines "health care treatment decision" as:

> a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

§ 88.001(5).

hospital stay although her doctor recommended a longer period. *Roark v. Humana, Inc.* 307 F.3d 298, 302 (5th Cir. 2002). Similarly, Mr. Davila brought suit in state court against his HMO, Aetna, under the THCLA alleging that his bleeding ulcers and near death resulted from Aetna's requirement that Mr. Davila use a different medication than the physician prescribed. *Id.* at 303. Both plaintiffs alleged that their respective HMOs failed to exercise ordinary care in making medical necessity decisions which proximately caused their injuries, and sought compensatory damages. (Joint Appendix, JA-188, Calad Complaint; Aetna Petitioners Appendix, 70A, Davila Complaint.)

CIGNA and Aetna each removed these actions to the United State District Court for the Northern District of Texas, arguing that they were completely preempted under ERISA section 502(a) because plaintiffs' claims were, in essence, merely claims for wrongful denial of benefits from their employer sponsored health insurance. *Roark,* 307 F.3d at 302-303. The district court denied plaintiffs' motions to remand and ordered that the claims be dismissed under Fed. R. Civ. P. 12(b)(6) based upon Section 502 of ERISA. *Id.* at 305. In the consolidated appeal, the Fifth Circuit stated "[b]ecause we conclude that § 502(a) does not displace Calad's or Davila's claims, the district court should have remanded." *Id.*

The Fifth Circuit's analysis of these cases turns on its interpretation of *Pegram v. Herdrich*, 530 U.S. 211 (2000) that mixed eligibility and treatment decisions made by HMOs are not preempted. The Fifth Circuit held that because the HMOs' decisions which plaintiffs challenge here are mixed eligibility and treatment decisions, plaintiffs' claims are not encompassed by § 502(a)(2), and there is no preemption under that provision. *Roark,* 307 F.3d at 308. The Fifth Circuit also determined that ERISA § 502(a)(1)(B), which establishes a federal cause of action for a claim for benefits under a plan, does not preempt the plaintiffs' THCLA claims. *Id.* The court reasoned that plaintiffs are not seeking benefits under their employer sponsored health care plan through the THCLA. Instead, they are seeking tort damages for the alleged medical negligence of the HMO in making health care treatment decisions.

Accordingly, their claims under the state statute do not conflict with ERISA's enforcement procedures for obtaining benefits and are not preempted under that provision either. *Id.* at 308-311.

B. Petitioners' Decisions Involved Medical Judgments.

In *Pegram*, the Court unanimously held that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA." 530 U.S. at 237. In determining whether the allegations in *Pegram* could constitute a claim under ERISA for breach of fiduciary duty, and thus fell within the kind of claims Congress intended ERISA to cover, the Court examined the facts in that case to determine how the claims should characterized. The opinion recognized that most managed care coverage decisions are mixed decisions involving when-and-how type questions, with no practical way to untangle eligibility from treatment decisions, and that the decisions in *Pegram* were mixed in nature. *Id.* at 228-29. *Pegram* was not a preemption case, but the opinion nevertheless distinguished eligibility decisions, which would be subject to ERISA's fiduciary duties, from treatment decisions, which were not fiduciary in nature and not something Congress contemplated would fall under ERISA regulation. *Id.* at 231 ("We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.") The Court implied that mixed decisions would not be preempted because allowing a plaintiff to challenge an HMO's mixed eligibility and treatment decision under ERISA's fiduciary standards would have presented a "puzzling issue of preemption," seeming "to be a prescription for preemption of state malpractice law" which the Court did not countenance. *Id.* at 236.

Because these cases present themselves in the posture of a review of removal petitions, the facts have not been fully developed below. But an examination of the available facts lead AARP and the National Partnership to conclude that these cases present the sorts of mixed decisions which *Pegram* indicated should not preempted because they are not the sort of

decisions which Congress intended to fall within ERISA's purview.

The facts clearly indicate that CIGNA made a mixed medical/eligibility determination in Ms. Calad's case. CIGNA's nurse decided Ms. Calad did not need another night in the hospital. CIGNA, although it disputes the relevance of the issue, acknowledges that the decision to discharge her earlier than her treating physician recommended was a benefits determination which involved the exercise of medical judgment. CIGNA, Brf. at 27.

Aetna asserts its denial was strictly a benefit decision which did not involve a medical decision, and that there was nothing "mixed" about it. Aetna Brf. at 15. The record suggests otherwise. The facts in the record surrounding Aetna's denial of Vioxx for Mr. Davila which would have been before the lower courts are contained in the Davila Complaint and its attachments reproduced in Aetna Petitioner's Appendix (Pet. App.), at 64a-81a. The Complaint states that coverage for Vioxx was refused despite Dr. Lopez's protests. (Pet. App. 68a.) Dr. Lopez's affidavit attached to the Complaint states that he contacted Aetna after Aetna refused "to fill the prescription." (Pet. App. 77a.) Dr. Lopez also stated that "[r]educing the likelihood of gastrointestinal toxicity was one of my chief concerns I had with respect to prescribing Vioxx for Mr. Davila." *Id.*

Without citation to the record, Aetna asserts that Dr. Lopez did not represent to Aetna that Mr. Davila had a contraindication, intolerance or allergy to the other drugs on Aetna's formulary. (Aetna Brf. at 9.) These would be the conditions precedent for Vioxx to be covered without a trial of two other drugs on the formulary. (Pet. App. 80a.) The record does not indicate if Aetna's decision maker asked Dr. Lopez whether the other drugs were contraindicated or not. But Aetna unequivocally sent a letter to Dr. Lopez stating that "based on the review of information submitted to us, your request to authorize payment for the Formulary excluded medication has been denied." *(Id.)* This demonstrates that Aetna was weighing whether there was sufficient medical evidence to

demonstrate Vioxx was medically necessary in Mr. Davila's case, or whether the other drugs on its formulary were as likely to be equally effective, and therefore, Vioxx was not medically necessary. There may be a factual question over what information was exchanged between the treating physician and the decision maker at Aetna, but from the facts we have in the record, it can be determined that Aetna's denial was based, at least in part, upon its decision of a medical question.

C. Where Medical Judgment Is Used To Determine Eligibility For ERISA Covered Benefits, Liability Claims for Personal Injuries Resulting From that Judgment Should Go Forward in State Court.

These cases present an extension of the question facing the Court in *Pegram*. In *Pegram*, the question was whether Congress meant for challenges to managed health care decisions blending medical judgment and eligibility determinations to come within ERISA's fiduciary obligations and provide for federal jurisdiction. Determining the answer to be no, the Court held the challenge did not state an ERISA claim. *Pegram*, 530 U.S. at 237. In these cases, the question is whether Congress intended federal jurisdiction under ERISA over these mixed decisions to be so complete that it meant to deprive states of their jurisdiction to regulate them – even where ERISA does not provide redress for a similar claim.

Congressional purpose is the ultimate touchstone of preemption analysis. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). This Court has stated that the historic police powers of the States are not to be superseded by federal law unless Congress' intent to do so is clear. *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Under the THCLA, the State of Texas is regulating in an area of traditional state concern – liability for medical negligence -- thereby raising the presumption against preemption. To overcome that presumption, Petitioners would have to show that in enacting ERISA, Congress clearly meant to strip States of their historic function of regulating health care. This seems improbable because Congress' primary purpose behind enactment of ERISA was to ensure that

employees received the retirement pension benefits to which they were entitled; health plans were not the focus of Congress' concern. ABA Section of Labor and Employment Law, EMPLOYEE BENEFITS LAW lxviii-lxix (2d ed. 2000). ERISA's declared principal purpose is "to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997)(citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); ERISA § 2(b), 29 U.S.C. § 1001(b).

Among the ways participants and beneficiaries were to be protected was by ERISA providing for "appropriate remedies, sanctions, and ready access to the Federal courts." ERISA § 2(b), 29 U.S.C. § 1001(b). While Congress was considering what were appropriate remedies for wrongful denial of employee benefits, if it intended to take the draconian step of prohibiting state liability for health plans' medical negligence, surely it would have said so directly. Allowing state law liability for personal injury caused by a HMO's negligent medical decision in addition to providing federal remedies for benefit determinations does not interfere with the goal of protecting participants and beneficiaries. Therefore, it is unlikely that Congress would have considered it necessary to usurp state court jurisdiction on this issue.

The Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) held that ERISA prohibits any remedy for benefits in addition to those specifically enumerated in ERISA's civil enforcement provisions under § 502(a). Here respondents are not seeking plan benefits and so are not seeking additional remedies to obtain those benefits. A finding of liability under THCLA would not result in an award of the benefits, so it does not provide an alternative enforcement mechanism. *Travelers*, 514 U.S. at 657-60; *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Blue Cross of California v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996).

A number of Circuit Courts have found that ERISA does not completely preempt state tort claims for violation of state privacy and other rights simply because the alleged conduct arose from the investigation of an employee's eligibility for

benefits. *See Dishman v. UNUM Life Ins. Co. of Am.*, 250 F.3d 1272, *reh'g en banc denied*, 269 F.3d 974 (9th Cir. 2001) (ERISA does not preempt a state tort claim alleging that health insurer's private investigators violated claimant's privacy rights when investigating claimant for claim fraud). *Accord*, *Darcangelo v. Verizon Communications Inc.*, 292 F.3d 181 (4th Cir. 2002) (no preemption of state claims for invasion of privacy, negligence, unfair and deceptive trade practices and medical privacy violations where complaint alleges wrongful conduct on the part of employer and plan administrator unrelated to their duties under the plan); *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (no preemption of common law fraud claims against participant who failed to inform the fund that he had divorced his wife in order to maintain her as an insured dependent in the plan so she could receive benefits). The claims of Davila and Calad are no different. They make claims separate and different from merely a claim for benefits.

Not every mixed eligibility and treatment claim will provide a state cause of action. If participants complain about the failure to receive benefits, and seek those benefits as opposed to seeking damages based upon a claim that a negligent medical necessity determination resulted in their injury, then the participants will have to sue under ERISA for failure to receive their benefits. *Cf. Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (even where independent review finds HMO's denial based on medical necessity was wrong, participant still must sue under ERISA to receive benefit). But where the claim is that the HMO did not exercise care in making the medical judgment, state law should survive preemption under the logic of *Pegram*, 530 U.S. at 237 (refusal to federalize medical malpractice suits).

Thus, in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed, sub nom. Vytra Healthcare v. Cicio*, 72 U.S.L.W. 3093 (U.S. Jul. 11, 2003)(No. 03-69), where medical judgment was exercised in the denial of health benefits as demonstrated by the exchange between the treating physician and the HMO's medical director, the Second Circuit found no preemption. In that case, Mr. Cicio was diagnosed with multiple myeloma. His

treating physician asked for approval to treat Mr. Cicio with "high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma." *Cicio*, 321 F.3d at 87. This request was denied by the HMO. There then ensued a exchange of letters between the doctors, resulting in approval of "a single stem cell transplant", but still denying "tandem stem cell transplant." *Id.* at 88. There was no question that Mr. Cicio needed treatment for his cancer or that he was eligible for treatment. The exchange between the doctors indicated the discussion was over which was the appropriate treatment for his cancer – single stem or double stem transplant. The Second Circuit, applying *Pegram*, held that an HMO medical director's decision denying an HMO participant one form of treatment as experimental and approving another was both a medical treatment decision and a contract interpretation decision, and that the state medical malpractice claim was therefore not preempted because it was based upon a mixed eligibility and treatment decision.

Although ERISA's § 514 "relates to" conflict preemption analysis is not controlling here because removal was based upon complete preemption under § 502, that analysis also supports Respondents' position. The Court has maintained Congress intended to preempt only state laws which refer to or have a significant connection with an ERISA plan. In *Travelers*, the Court recognized that three types of state laws will always be preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. 514 U.S. at 645. These types of state laws are certainly within the field that Congress intended to occupy when it enacted ERISA and will always have a connection to an ERISA plan. *See id.* at 657-60. The THCLA does not mandate the distribution, payment or receipt of benefits. The THCLA does not mandate benefit structures or their administration because it does not address who will receive benefits, the kind of benefits to be paid, or

how those benefits will be paid. Nor does THCLA even purport to provide an additional means of getting plan benefits. *Compare Egelhoff v. Egelhoff ex rel Breiner*, 532 U.S. 141 (2001); *Boggs*, 520 U.S. 833 (1997); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). The THCLA does not bind the employer or the plan administrator to any particular choice concerning benefits or administrative practices. Instead it is limited to providing for a claim of liability against a medical entity which fails to exercise ordinary care in making medical necessity decisions, an area of traditional state concern, which this Court has recognized is not preempted. *See Travelers*, 514 U.S. at 654-55, 661; *Pegram*, 530 U.S. at 237. The Fifth Circuit's decision that the cases should have been remanded to state court should be affirmed.

II. HOLDING HMOS RESPONSIBLE FOR CAUSING PERSONAL INJURIES WILL NOT JEOPARDIZE EMPLOYER BASED HEALTH CARE COVERAGE.

A. Permitting Liability for Failure to Exercise Appropriate Medical Judgment Will Not Be Prohibitively Expensive or Reduce Access to Health Care

CIGNA posits that "it can hardly be disputed that imposing . . . medical malpractice . . . on employee health benefit coverage decisions will vastly increase the costs of providing benefits, all but guaranteeing that less coverage and thus less health care overall – will be provided to the nation's employees and union members." CIGNA Brf. at 48. Petitioners' *amici* argue that permitting state suits will cause plan sponsors to restrict benefits, increase employee cost sharing, replace "discretionary decisions with categorical exclusions," or "discontinue, or decline to institute health benefits." *Amicus* brief of AAHP-HIAA, *et al.*, at 5. These dire predictions are overstated.

The direct costs of medical malpractice, measured by insurance premiums paid by physicians, hospitals, HMOs, and other providers, account for less than 1 percent of national

health care expenditures. U.S. Congress, Office of the Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-1 19 (Washington, DC: U.S. Government Printing Office, October 1993), at 5 (OTA). OTA was reporting on data from the early 1990s, but these costs have been consistent over time, even declining in the last ten years. Malpractice premiums accounted for six-tenths of one percent of total U.S. Health Care costs in 2000, a decline from nearly one percent in 1988.[4/] For 2001, it was 0.43% of total national health care expenditures.[5/]

Holding managed care entities accountable for the injuries which they proximately cause will not substantially increase the costs of health care, and any rise in employer sponsored premiums as a result would likely be minimal. The Congressional Budget Office (CBO) estimated the rise in premiums for employers sponsored health care if Congress had passed the patient protection legislation, S.872, the Bipartisan Patient Protection Act introduced in June 2001 which included a provision allowing for civil liability. The increase was estimated to be a modest 0.8%.[6/]

[4/] Testimony of Travis Plunkett, Legislative Director Consumer Federation of America, Regarding Medical Malpractice Insurance Rates: Hearings Before the Subcomm. on Health of the House Comm. on Energy and Commerce (July 17, 2002) Exhibit B, *available at* http://www.consumerfed.org/Med_Mal_House_testimony.pdf.

[5/] This is based upon comparing $1.4 trillion in total health care costs in 2001as reported by the Centers for Medicare and Medicaid Services (see, http://www.cms.gov/media/press/release.asp?Counter=935 with A.M. Best figures of approximately $6 billion for medical malpractice premiums.

[6/] Letter from Dan L. Crippen, Director, CBO, to Senator Kennedy, Chairman, Comm. on Health, Education, Labor, and Pensions, United States Senate, Cost Estimate for S. 872, the Bipartisan Patient Protection Act, (June13,2001) *available at* http://www.cbo.gov/showdoc.cfm?index=2874&sequence=0. CBO also estimated current federal legislative proposals to limit tort liability for physician malpractice would " lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums

Moreover, a recent evaluation of medical malpractice insurance premiums and their relationship to what liability insurers actually pay out in losses disputes the notion that increased liabilities have made health care unaffordable.[7/] The study found that while insurer payouts for jury awards, settlements and other costs over the last thirty years directly tracked the rate of medical inflation, medical insurance premiums rose and fell in relationship with the state of the economy. The study concluded that insurance companies raised physician's malpractice premium rates not because of an "explosion" in payouts, but because they sought ways "to make up for declining interest rates and market-based investment losses."[8/]

Petitioners and their *amici* are incorrect when they argue that allowing health plans and insurers to be liable for medical error would drive up health care costs to the point where it will undermine Congress's goal of encouraging employer based coverage and employers will reflexively stop providing coverage. While there is no doubt that rising health care costs pose threats to the availability of sources of health care coverage, both public and private, liability for medical negligence simply does not drive the availability of health care. For example, while the United States General Accounting Office (GAO) found that malpractice premiums for health care providers were rising, they concluded that those increases "did not affect access to health care on a widespread basis" even in states where they confirmed instances of reported problems.[9/]

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would be comparably small." CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, at 6.

[7/] Americans for Insurance Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003, November 2003, at 8.

[8/] *Id.*

[9/] GAO, Highlights of GAO-03-386, Medical Malpractice, Implications of Rising Premiums on Access to Health Care, August 2003.

While insurers have raised the cost for employers to purchase health benefit coverage, employers do not attribute the increase to liability for medical negligence or to other costs associated with liability. Nor are employers drastically cutting health benefits in response to the increases. On average insurers increased premiums for employer based health insurance by 13.9% between 2002 and 2003. The researchers at the Kaiser Family Foundation explain:

> The high rate of premium growth in 2003 appears to have been driven by a combination of rapid inflation in the costs for health care services and insurers efforts to emphasize profitability in their pricing. Premium equivalents for self-insured plans (a proxy estimate for medical claims expenses) grew by a lower amount (12.4%) than premiums for fully insured plans, which increased 15.6% this year. This finding may indicate that part of the rise in health care premiums is due to insurers expanding their underwriting gains.[10/]

Employers reported that the major factors contributing to the increases were higher prescription drug spending and higher hospital costs – with no mention of malpractice insurance or other costs associated with liability. The other factors reported were higher spending for physicians, higher insurance company profits, better medical technology, and an aging population.[11/] And although there have been three consecutive years of double digit premium increases, "many employers say . . . that they will increase contributions and cost sharing next year, but very few say they will reduce eligibility or drop coverage."[12/] Changes in the percentage of employers offering coverage have more to do with conditions in the general

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[10/] Kaiser Family Foundation and Health Research and Educational Trust, (Kaiser) Employer Health Benefits 2003 Summary of Findings, Employer Health Benefits 2003 Annual Survey, at 3, available at www.kff.org.

[11/] Kaiser, Cost of Health Insurance, Secton 1, Employer Health Benefits 2003 Annual Survey, at 29, Exhibit 1.11.

[12/] *supra,* note 10, at 1.

economy than increases in malpractice insurance rates. Kaiser reports "the weakened economy and escalating premiums do not appear to have caused a drop in the percentage of employers offering health insurance coverage from last year, but the percentage of firms offering coverage is lower than its pre-recession high (69%) in 2000. In 2003, 66% of all firms offered" health benefits.[13/]

Aetna argues: "affirmance of the decision below would deal a severe blow to the American economy." Aetna Brf. at 44. It argues that permitting managed care entities to be subject to a state law duty of ordinary care when making health care treatment decisions would "decree an end" to managed care. *Id.* But the American economy has long been used to the notion that parties are liable for causing the injuries of others; it is one of the primary reasons the insurance industry exists.[14/] Managed care is the dominant health care delivery mode, a healthy, profitable business model unlikely to wither because of an increased liability potential.[15/]

[13/] *Id.* at 5.

[14/] It further seems likely that HMOs have already undertaken to insure themselves against such liabilities as at least two Federal Circuits have found ERISA does not preempt state laws regulating medical negligence of managed care entities. *Cicio v. Does*, *supra* at 10; *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3rd Cir. 1994) *cert. denied*, 516 U.S. 1009 (1995); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001)(on remand for reconsideration in light of *Pegram v. Herdrich*), cert. denied sub nom, *U.S. Healthcare Systems of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). Some state courts have found also managed care entities vicariously liable under several different theories. *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E. 2d 1119, 1128 (Ill. 2000); *McClellan v. Health Maint. Org. of Pa.*, 604 A.2d 1053 (Pa. Super. Ct. 1992); *Decker v. Saini*, No. 88-361768 NH, 1991 WL 277590 at 3-4 (Mich. Cir. Ct. Sept. 1, 1991).

[15/] As of 2001, 93% of employees with employer-sponsored health care received that care through some form of managed care: 48% are in preferred provider organizations (PPOs), 23% are enrolled in health maintenance organizations (HMOs) and 22% are in point of service (POS) plans. Jon R. Gabel, Gail A. Jensen & Samantha Hawkins, *Self-Insurance in Times of Growing and Retreating Managed Care*, HEALTH AFF., March/April 2003, at 202. Employer-sponsored health insurance covers "159 million active workers and their dependents as well as sixteen million retirees." *Id.* Approximately half of these employees are covered by self-insured plans not subject to state insurance regulation, but half have been subject to state regulation of their businesses through insurance laws. *Id.* at 203. This Court has recognized dual federal and state regulation of ERISA plans for years, and those plans subject to state insurance regulation have not disappeared. *See, e.g., Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (states may mandate benefits in insured ERISA plans).

In testimony before the Senate, the Assistant Secretary of the then named Pension and Welfare Benefits Administration of the Department of Labor, the federal agency responsible for administering ERISA, discussed the cost implications of allowing state law remedies for injuries caused by improper denial of health benefit coverage by ERISA health plans.

> The best evidence regarding cost impact exists in those markets where expanded remedies already exist. There is nothing in these markets to show that these remedies result in larger premium costs. For example, participants in group health plans covering State and local employees are outside ERISA and often have access to full State law remedies for injuries that result from improper delay and denial of benefit claims. Yet insurers and HMOs compete aggressively for State and local group business, and there is no evidence that insurers charge higher prices to these groups because of the greater liability exposure associated with them. Thus, it seems highly unlikely that the availability of additional remedies would force employers to retreat from offering health coverage.

Testimony of Olena Berg, before the Senate Subcommittee on Labor, Health and Human Services, and Education, in May 1998.

In short, the ominous pronouncements of those urging preemption remind one of the statement attributed to Mark Twain, "reports of my death have been greatly exaggerated."[16/]

B. States Which Allow Managed Care Liability Have Not Seen an "Explosion" of Litigation.

Ten states have enacted laws creating managed care liability since 1997, with Texas having its statute in place longest. A study of these laws reported that there was little in the way of litigation under these statutes in any of the states, and the authors concluded that this was not principally due to "ERISA preemption, but, rather, to the costs and complexities of suing a health plan, which deter lawyers from including this additional defendant in medical malpractice cases."[17/]

[16/] Many different sources have slightly different versions of the quotation. The following information comes from: Respectfully Quoted: A Dictionary of Quotations Requested from the Congressional Research Service. Suzy Platt, ed. Washington: Library of Congress. p. 76 (1989):

> In 1897, Twain was living in London where a cousin, Dr. Jim Clemens, fell ill. The newspapers, believing Twain was near death, sent reporters to investigate. Twain made his remark when the correspondent for the *Evening Sun* told him his death had been reported in New York, and asked what he should cable in reply. Mark Twain (Samuel L. Clemens), "The Report of My Death," Mark Twain in Eruption, ed. Bernard DeVoto, pp. 252-53 (1940). Albert Bigelow Paine, Mark Twain, vol. 2, chapter 197, p. 1039 (1912), gives a slightly different version of the story, ending, "Just say the report of my death has been grossly exaggerated."
> Often heard "...greatly exaggerated."

[17/] Mark A. Hall and Gail Agrawall, The Impact of State Managed Care Liability Statutes, Health Affairs, September/October 2003, Vo. 22, no. 5, 138, 141. Professors Hall and Agrawal wrote that the primary drivers of concerns about liability were pending large federal class actions brought under RICO and ERISA and large punitive damage awards in a few state cases prior to enactment of the MCO liability statutes. *Id* at 140.

But perhaps most interesting, this study found that the statutes did positively impact health plans' behavior by "focusing more attention on the potential for being sued when personal injury results from managed care restrictions. This heightened attention prompted many health plans to review their managed care practices from a legal risk-management perspective." [18/] Most health plans interviewed said that "liability is one of the factors that has caused them to improve their procedures for making coverage determinations."[19/] This suggests that liability for managed care entities will effectively reduce personal injuries because HMOs will have better practices, which should actually save the HMOs and ERISA plans money in the long run.

C. Arguments that Costs Will Increase Due to "Defensive" Spending are Unfounded.

CIGNA argues that if this Court decides ERISA does not preempt plaintiffs' state claims, that HMOs will engage in granting "defensive" coverage, authorize unnecessary care and drive up the cost of benefits. CIGNA Brf. at 49. Lamenting the "enormous pressure medical malpractice litigation is imposing on the delivery of health care in this country," CIGNA says "at least five to nine percent of total medical expenditures"can be attributed to physicians' defensive behavior to avoid litigation, citing, Daniel Kessler and Mark McClellan, The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care, 60 Law & Contemp. Probs. 81, 83 (1997). CIGNA Brf. at 48.

Kessler and McClellan were studying if state tort reforms such as caps on damages reduced defensive medical practice. They concluded it did because they saw evidence of slower growth in health care expenditures in the range of from 5 to

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[18/] *Id.* at 142.

[19/] *Id.*

9%.[20/] However, their study does not support Petitioners' point. First of all, the study evaluated limiting liability for physicians, not state law immunity for HMOs. Moreover, in August 2003, the General Accounting Office (GAO) examined the data used in the Kessler and McClellan study and found that because their work was limited to a review of hospital costs for elderly Medicare patients with two types of heart disease, these costs could not be generalized across all services, populations, and health conditions, and the study's analysis was also flawed because it did not fully consider the range of other factors that can influence medical spending.

In fact, the GAO criticized the Department of Health and Human Services (HHS) for using these same Kessler and McClellan figures in its recent reports to estimate total national health care spending on defensive medicine saying these estimates were "not reliable."[21/] The GAO determined that while most empirical published studies addressing the issue indicate that physicians do practice some defensive medicine in response to perceived malpractice pressures, it was impossible to use these studies to estimate the extent and cost to the health care system as a whole, given the low response rates and imprecise nature of measurements used.[22/]

When the Congressional Budget Office (CBO) replicated and expanded the scope of the Kessler and McCllelan studies to include a broader set of conditions "it found no evidence that restrictions on tort liability reduce medical spending. Moreover, using a different set of data, CBO found no statistically significant difference in per capita health care spending between states with and without limits on malpractice

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[20/] Kessler and McClellan, at 83.

[21/] GAO, Medical Malpractice Implications of Rising Premiums on Access to Health Care (GAO-03-836, August 2003), at 29. Kessler and McClellan did a follow-up study in 2000 and concluded that when they controlled for managed care penetration, estimated savings fell to about 4 percent. *Id.*

[22/] *Id.* at 26.

torts."[23/] CBO pointed out that "so-called defensive medicine may be motivated less by liability concerns than by income it generates for physicians or by the positive (albeit small) benefits for patients" and concluded, based on its own research and other studies it reviewed, that any savings from defensive medicine by limiting liability would be very small.[24/]

Studies have simply not established that holding HMOs accountable in state courts will significantly drive up health care costs, or conversely, that immunizing HMOs from state law liability will result in substantial health care savings.

III. ALLOWING STATE LAW LIABILITY MEANS INJURED PEOPLE HAVE AN OPPORTUNITY TO OBTAIN REDRESS

Affirming the right of states to ensure that those who exercise medical judgment do so with ordinary care means that as a practical matter, insurers would have to insure themselves against the unlikely event that they would lose malpractice litigation under similar state laws.[25/] This is a marginal cost compared to the catastrophic losses any given individual with significant personal injuries could face when those injuries arise from an HMO's negligent treatment decision but the person is deprived of any remedy or redress.

In the end, it comes down to a question of equity. The CBO's recent statement regarding limiting liability for physicians is equally applicable to the question of whether HMOs should be liable for state law damages.

[23/] CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, 6-7 (available at ftp://ftp.cbo.gov/49xx/doc4968/01-08-MedicalMalpractice.pdf)

[24/] *Id.*, at 6.

[25/] Only about 30% of medical malpractice litigation claims result in an insurance payout. *Id.* at 4.

> [T]he evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Thus, choices about specific proposals may hinge more on their implications for equity—in particular, on their effects on health care providers, patients injured through malpractice, and users of the health care system in general.

CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, at 7. State courts have always balanced these equities and there is no logical reason to strip them of this power just because the health care happened to be paid for primarily by the employer rather than the employee.

CONCLUSION

For the above reasons, *amici* urge the Court to affirm the Fifth Circuit's decision that ERISA does not preempt the THCLA.

January 22, 2004

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AETNA HEALTH INC., FKA AETNA U.S. HEALTHCARE INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION,

Petitioner,

v.

RUBY R. CALAD, et al.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF FAMILIES USA, et al. AS *AMICI CURIAE* IN SUPPORT OF THE RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

Amici are consumer, disease and disability organizations that have worked for years to ensure that health care consumers receive affordable, high-quality health care coverage. Families USA is a national nonprofit, nonpartisan organization dedicated to achieving high-quality, affordable health care for all Americans. Through its Health Assistance Partnership project, Families USA works directly with patient advocates nationwide. These advocates are helping patients in all 50 states who have been denied critical treatments and services to negotiate with their health plans. The Arthritis Foundation is the nation's leading nonprofit organization dedicated to improving the lives of 70 million Americans through leadership in the prevention, control and cure of arthritis and related diseases. The Epilepsy Foundation is the sole national, charitable voluntary health organization dedicated to advancing the interests of the more than 2.5 million people with epilepsy and seizure disorders. The Spina Bifida Association of America's mission is to promote the prevention of spina bifida and to enhance the lives of all affected, it serves as the national representative of almost 60 chapters. The Brain Injury Association is the only national nonprofit agency working on behalf of the more than 1.5 million Americans who sustain a brain injury each year, the estimated more than 5.3 million Americans living with

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[1] Pursuant to Supreme Court Rule 37.6, amici state that no person or entity other than the amici curiae and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court Rule 37.3(a). Copies of the consent letters have been filed with the clerk.

permanent disabilities resulting from a brain injury, and their circles of support.

The American Association of People with Disabilities is the largest national cross-disability membership organization working to improve the political and economic empowerment of the 56 million children and adults with disabilities in the United States. The Arc of the United States, through its nearly 900 state and local chapters, is the largest national nonpartisan, nonprofit, voluntary organization in the United States devoted solely to the welfare of the more than seven million children and adults with mental retardation and related developmental disabilities and their families. The National Organization on Disability, founded in 1982, promotes the full and equal participation and contribution of America's 54 million men, women and children with disabilities in all aspects of life. ADAPT is a national nonprofit consumer organization whose members have severe disabilities and often rely on the health care system to remain as functional and independent as possible. Family Voices is a nonpartisan, nonprofit membership organization with 50,000 grassroots members and state coordinators in all 50 states and the District of Columbia, and is dedicated to addressing the needs and interests of children with special health care needs and their families. United Spinal Association (formerly Eastern Paralyzed Veterans Association) is a membership organization comprised of individuals who have incurred spinal cord injury or disease and who reside throughout the United States. Amputee Coalition of America is a national, nonprofit amputee consumer educational organization representing people who have experienced amputation or are born with limb differences. National Association of Protection and Advocacy Systems is the voluntary national membership organization of a nationwide network of congressionally mandated, legally based disability rights agencies. The Disability Rights Education and Defense

Fund, founded in 1979 by people with disabilities and parents of children with disabilities, is a national law and policy center dedicated to protecting and advancing the civil rights of people with disabilities. The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities.

More than 120 million Americans receive their health care through managed care plans sponsored by private employers. Many of these Americans have chronic conditions or disabilities that necessitate frequent use of health care services. As patients in the health care system, they are likely to encounter denials of care due, in part, to the financial incentives inherent in many managed care arrangements. Many people with disabilities and chronic conditions are vulnerable consumers, ill-equipped to advocate for themselves in a timely manner. These patients tend to place great trust in their health plans to provide the services that are in their best medical interests in order to help them lead healthy and productive lives.

Amici believe that a patient's right to sue his or her health plan in state court for medically inappropriate denials of care is a powerful incentive for managed care plans to provide quality health care services to all patients, even those with extensive health care needs. A system that recognizes that a health plan's inappropriate medical decisions may result in serious consequences enhances accountability and quality health care for all Americans. Therefore, amici urge the Court to affirm the decisions of the Fifth Circuit in *Calad v. Cigna Healthcare of Texas, Inc.* and *Davila v. Aetna U.S. Healthcare, Inc.*

SUMMARY OF ARGUMENT

The shift many Americans have experienced in their health care from a fee-for-service arrangement to a managed care model has profoundly influenced the way people receive their health care and the kinds of decisions made each day by health insurers, including those insuring employer-sponsored plans. As this Court recognized in *Pegram v. Herdrich*, 530 U.S. 211 (2000), managed care entails direct influence and control over treatment by the parties responsible for paying for it. Indeed, the insurer's application of independent medical judgment to treatment recommendations by physicians is one of managed care's central features. Managed care entities routinely make decisions that determine what medical care a patient should receive while simultaneously determining what medical care the plan will cover, usually by judging whether a patient's requested treatment meets a plan requirement of "medical necessity."

The *Pegram* Court examined the dual nature of medical necessity determinations—"mixed treatment and eligibility decisions"—in the context of an action for breach of fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, and determined that the partially medical nature of the decision made it non-fiduciary in nature. This distinction between plan administration on the one hand (regulated entirely by ERISA), and the exercise of professional judgment subject to standards of ordinary care on the other (regulated by state law even where an ERISA plan is involved), has long been recognized by courts as an important component of ERISA preemption analysis. ERISA simply does not contemplate the regulation of medical judgments, any more than it regulates the provision of other non-fiduciary professional services to an employee benefit plan.

ERISA preemption is not implicated where, as here, a patient has no cause of action under ERISA. The preemption question in this case turns on whether Respondents' state law claims state a cause of action that can be brought pursuant to ERISA Section 502, 29 U.S.C. § 1132. In particular, ERISA Section 502(a)(1)(B) provides a cause of action only where plan benefits are past due or will become due in the future. Where a participant has been injured by a mixed eligibility and treatment decision and, as a result, the denied benefits are no longer relevant or available to the participant, a state law cause of action for violation of the standard of care does not duplicate any ERISA claim.

The denials of Ms. Calad's and Mr. Davila's requests for particular treatments were mixed treatment and eligibility decisions like that analyzed in *Pegram*. The consequences of those decisions do not give rise to any cause of action under ERISA Section 502. The decision of the Fifth Circuit, finding no ERISA preemption and hence no federal jurisdiction over Respondents' claims, should be affirmed.

ARGUMENT

I. MANAGED CARE ENTITIES SEEK TO INDUCE A NEW, MORE COST-CONSCIOUS, AND SOMETIMES HIGHER-RISK STYLE OF MEDICAL PRACTICE.

As this Court recognized in *Pegram*, the previously distinct activities of paying for health care and providing health care services to individual patients are now "inextricably mixed." 530 U.S. at 229. Large health insurers and/or administrators, such as petitioners Aetna and Cigna in these cases, pay for (or administer payment for) the health care of millions of individuals and simultaneously seek, through financial incentives, practice guidelines, utilization review criteria, and other means, to shape and influence

the way doctors practice medicine and the care that patients actually receive. *See, e.g.*, David Blumenthal, *Effects of Market Reforms on Doctors and Their Patients*, 15 Health Affairs 170, 173-77 (Summer 1996). This is not a *sub rosa* enterprise. The explicit goal of "managed care" is to *manage care*, and the consequence is a new, more cost-conscious and sometimes higher-risk style of medical practice. *See, e.g.*, *Pegram*, 530 U.S. at 218-21 (citing literature, and noting that rationing "necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so)," *id.* at 221).

Indeed, when it is in their immediate legal interest to do so, managed care entities argue that they *are* engaged exclusively or primarily in health care delivery rather than in insurance or payment for care. *See, e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366, 370 (2002); *McEvoy v. Group Health Cooperative of Eau Claire*, 213 Wis.2d 507, 570 N.W.2d 397 (Wis. 1997). The major private non-profit national accrediting entity for managed care, the National Commission on Quality Assurance (NCQA), measures such quality factors in a managed care entity as adolescent immunization status, antidepressant medication management, beta blocker treatment after a heart attack, screening for breast and cervical cancer, and comprehensive diabetes care. NCQA, Managed Care Organization Accreditation at 3, *available at* http://www.ncqa.org/Programs/Accreditation/MCO/images/1228_MCO%20Insert.pdf (last visited Jan. 16, 2004). In short, as this Court recognized in *Pegram*, far from being passive payors for care, managed care entities are actively involved in managing the quality of health care, and this role is manifested in the mixed eligibility and treatment decisions these entities make as to the care to be afforded to patients who are ERISA plan participants.

The facts in *Pegram* highlight the "intertwined" nature of the treatment and eligibility decisions made by managed care entities that contract with ERISA plans. Dr. Pegram was the treating physician and an employee/owner of the HMO. She decided that it was not necessary to send Ms. Herdrich to an out-of-network local hospital for a speedy ultrasound test. 530 U.S. at 215, 229. That decision was *simultaneously* a decision about the medically proper treatment for Ms. Herdrich as an individual, governed by the state law of medical malpractice, and about what the HMO would (and would not) pay for, governed by the plan contract. *See id.* at 229. Dr. Pegram's decision to subject Ms. Herdrich to the cheaper, delayed diagnostic test imposed additional risks, which materialized when Ms. Herdrich's appendix ruptured. *Id.* at 215.

Petitioners Aetna and Cigna's mixed eligibility and treatment decisions in these cases reflect the dual goals of managed care: to contain costs and influence the health care services actually delivered. Thus, Aetna's letter to Dr. Lopez refusing to pay for Vioxx and offering to pay for other pain medications begins as follows: "*As part of our commitment to provide access to quality care for our members*, Aetna U.S. Healthcare conducts a utilization review program with physicians, hospitals, and others who provide care, services and equipment to our members." App. to Pet'r's Cert. Pet. 80a (emphasis added). Cigna offers its patients "Case Management," which has as its stated goal

> to *ensure that patients receive appropriate care in the most effective setting possible* . . . . Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager *will help coordinate the treatment program and arrange for necessary resources.*

J.A. 204-05 (emphasis added). While nothing in the record establishes that such detailed Case Management was provided to Ms. Calad, the "Healthcare Management Guideline" that Cigna apparently used as the basis for discharging Ms. Calad from the hospital one day after her hysterectomy is titled "Case Management: Coordinate Care and Anticipate Needs." *Id.* at 295.

To be sure, Aetna, Cigna, and the managed care industry in general do not formally prohibit patients from paying out of their own funds for care that is denied on the basis of a lack of medical necessity. *See, e.g.*, Amicus Br. of American Association of Health Plans-Health Insurance Association of America, Inc. (AAHP-HIAA) 11 n.7. However, a great many patients cannot afford to purchase the services or pharmaceuticals for which managed care entities refuse to pay. As a practical matter, the decision by a managed care entity not to authorize payment for a certain treatment or course of action, often combined with the decision to pay for an alternative treatment or course of action, frequently dictates what care the patient will receive. *See, e.g.*, *Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1324 (5th Cir. 1992) (involving utilization reviewer's refusal to authorize continued hospitalization recommended by treating physician for patient with high-risk pregnancy, which, combined with authorization of part-time at-home nursing care, allegedly contributed to death of fetus); *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 463 (3d Cir. 2003) (Becker, J., concurring) (involving utilization reviewer's refusal to authorize a specially-designed tracheostomy tube, which, combined with authorization of standard tracheostomy tube, allegedly led to serious soft tissue and bone infection). Whether the patients in these cases accepted the treatments found medically necessary by the managed care entity because they could not afford the alternative or because they trusted the judgment of the managed care provider, the fact remains that the care authorized was the care provided.

As described above, in its coverage materials, accreditation standards, and communications with patients and providers, the managed care industry claims responsibility not only for lower costs but also for a high quality of patient care. As this Court and others have recognized, managed care seeks to influence, and does influence, the way providers practice and the services patients actually receive. *See, e.g.*, *Pegram*, 530 U.S. at 218-19; *Rush Prudential*, 536 U.S. at 366-67. When a managed care entity evaluates whether a requested treatment meets a plan requirement of "medical necessity" in a particular case, it determines what medical care the plan will cover while simultaneously determining what care a patient should receive. For these reasons, Aetna and Cigna cannot plausibly argue that they only made eligibility decisions and had no responsibility for the treatment (or lack of treatment) actually received by Ms. Calad and Mr. Davila.

II. INSTITUTIONS RESPONSIBLE FOR QUALITY OF CARE AND MANAGING MEDICAL RISK ARE TRADITIONALLY AND PROPERLY SUBJECT TO STATE LAW.

When hospitals became significant overseers of quality of care—a function reflected in the hospitals' own practices and accreditation standards—they were subjected to state licensure and to direct and vicarious tort liability. Thus, in *Darling v. Charleston Community Hospital*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), the court rejected a hospital's argument that it performed only administrative functions and that only physicians were responsible for health care services. The court found that argument inconsistent with hospitals' practices and licensing and accreditation standards. 33 Ill. 2d at 330-32. As managed care entities have assumed the same role through their influence on medical

practices and their accreditation by national organizations promoting their quality-enhancing function, they have been similarly subjected to state licensure, and (as recognized in *Pegram*) increasingly subjected to tort liability by state courts and legislatures for negligent exercises of medical judgment. *See, e.g., Jones v. Chi. HMO Ltd. of Ill.*, 191 Ill. 2d 278, 292, 730 N.E.2d 1119 (2000) (analogizing role of HMO to that of hospitals, and extending the *Darling* doctrine of institutional negligence to HMOs).

The literature indicates that the cost containment techniques of managed care directly affect the quality of care, in some cases by decreasing and, in others, by increasing risks to patients. For example, studies have found that managed care entities are better than fee-for-service providers at getting cardiac patients to take aspirin, but sometimes use lower-cost (and higher-mortality) hospitals for coronary artery bypass graft surgery. Joseph Gottfried & Frank A. Sloan, *The Quality of Managed Care: Evidence from the Medical Literature*, 65 Law & Contemp. Probs. 103, 107-08 (2002). Robert H. Miller and Howard S. Luft's 1997 literature survey (based on data primarily from the early 1990s) found evidence pointing both ways, with negative results focusing particularly on chronically ill and low-income enrollees. Robert H. Miller & Howard S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 Health Affairs 7, 14 (Sept./Oct. 1997).[2]

Amicus AAHP-HIAA points to studies that document how patients enrolled in managed care entities have received

[2] *See also Zamora-Quezada v. HealthTexas Med. Group of San Antonio*, 34 F. Supp. 2d 433, 442 (W.D. Tex. 1998) (denying motion to dismiss by Texas HMOs sued under the Americans With Disabilities Act by patients and former doctors who alleged that patients with chronic conditions were repeatedly given substandard care, and that physicians were terminated because they advocated for their disabled patients).

the same or better quality of care than that received by patients in fee-for-service programs. *See* AAHP-HIAA Amicus Br. at 14-19. Indeed, AAHP-HIAA argues that "insurers and administrators, who compete for the business of [employers] and their employees, have no incentive to design systems that deny coverage for no good reason," particularly when "denial of some relatively inexpensive item or service would likely lead to a bad medical outcome that would then require additional, much more expensive care." *Id.* at 12-13.

This logic may appear plausible at first glance, but it overlooks several countervailing factors. First, coverage denials often do not involve "inexpensive items," but rather expensive items such as hospitalization or long-term physical therapy, the denial of which increases risk and causes harm. *See, e.g., McEvoy*, 213 Wis. 2d at 514-16 (involving allegations that HMO medical director refused to authorize continued hospitalization for anorexic patient, and instead authorized outpatient services, causing patient to lose 22 percent of her weight and require re-hospitalization); *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 151 (4th Cir. 1996) (involving reviewing doctor's decision to deny continued intense physical therapy for infant with cerebral palsy). This is particularly true when a coverage denial will yield immediate savings, which the courts have recognized as creating a financial conflict of interest in coverage decisionmaking. *See, e.g., id.* at 152.

In addition, as noted by Judge Richard Posner, the "bad medical outcome" caused by HMO underservice might be death, which, by comparison with lengthy medical treatment, is the most profitable option for the HMO, given that no further benefits will be payable. *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic & Sec. Health Plan of Wis., Inc.*, 65 F.3d 1406, 1410 (7th Cir. 1995) ("[T]he HMO's incentive is to keep you healthy if it can but if you

get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."). The availability of countervailing patient causes of action is particularly important when the financial incentives of at-risk, prepaid managed care push toward underservice of the seriously ill. For this reason, the vacuum that would be left by ERISA preemption would prevent the managed care system from functioning optimally to minimize patient risk while maximizing the affordability of employer-sponsored plans. Echoing Judge Posner's point, Dudley et al. state that

> [t]here are many theoretical reasons to believe that simple [non risk-adjusted] prepayment creates incentives to provide high-quality care to the healthiest members of a population, but a lower quality of care to enrollees with chronic disease. There is, however, at least one theoretical feature of HMOs that mitigates the incentives to skimp on care: an HMO becomes a deep pocket for lawsuits.

R. Adams Dudley *et al.*, *The Impact of Financial Incentives on Quality of Health Care*, 76 Millbank Q. 649, 662 (1998).

As the Court correctly noted in *Pegram*, the point is not a blanket condemnation of managed care. *Pegram*, 530 U.S. at 221. All health care financing and delivery arrangements increase some types of risks and diminish others. The question posed by the cases before this Court is whether our established state-level political and legal framework for dealing with the risks, costs, and benefits of health care delivery will be permitted to carry out its traditional role, a role for which ERISA was not intended and which it cannot play.

III. DECISIONS BASED ON MEDICAL JUDGMENTS AND OTHER EXERCISES OF STATE-REGULATED PROFESSIONAL JUDGMENT ARE NOT REGULATED BY ERISA.

A. Decisions Involving the Exercise of Medical Judgment Are Not Regulated by ERISA.

In *Pegram*, the Court utilized a three-part framework for analyzing the types of decisions made by HMOs regarding patients. "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Pegram*, 530 U.S. at 228. In contrast, "treatment decisions" are "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* However, as discussed above, the Court went on to note that these decisions are often inextricably mixed together, because "most coverage questions are not simple yes-or-no questions," but are instead "when-and-how" questions: that is, "whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case." *Id.* at 228-29. Dr. Pegram's decision regarding Ms. Herdrich's treatment (like Cigna's decision regarding Ms. Calad and Aetna's decision regarding Mr. Davila) was a mixed eligibility and treatment decision. *See id.* at 229-30. These mixed eligibility-treatment decisions, *Pegram* held, were non-fiduciary in nature, and therefore Ms. Herdrich could not state an ERISA claim for breach of fiduciary duty based on such a decision. *Id.* at 231-37.

For current purposes, *Pegram*'s important distinction is between "pure eligibility decisions" and "mixed eligibility

and treatment decisions." A pure eligibility decision is a relatively mechanical application of an eligibility rule that does *not* depend on medical judgment about an individual patient. In *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002), for example, the HMO refused to accept a referral to a specialist from a patient's doctor because, contrary to the patient's understanding, his doctor was not on the list of approved primary care physicians under the plan. *Id.* at 332. The result was that the HMO would not allow Mr. Haynes to receive care from the specialist, and he lost his leg. *Id.* at 332-33. As unfair as the result in *Haynes* may appear, from an ERISA preemption perspective the case was correctly decided: the decision to refuse treatment was based on a mechanical application of plan terms rather than a medical judgment and was therefore a pure coverage decision subject to preemption under ERISA's express preemption provision, ERISA § 514, 29 U.S.C. § 1144. The decision in *Haynes* was wholly consistent with the *Pegram* framework.

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 43 (1987), in which the Court held preempted a plan participant's state-law claims for past-due disability benefits, also fits within that framework. Although medical facts may be relevant to decisions about whether individuals are entitled to monthly stipends by reason of "disability," such decisions differ fundamentally from decisions about a health care treatment's "medical necessity," because the former do not affect the medical treatment of the individual. Hence, Dedeaux's claim in *Pilot Life* that denial to him of disability insurance benefits had caused him harm was based solely on a denial of monetary benefits, not on a medical judgment as to treatment. The Pilot Life Insurance Co. did not wear two hats; its decisionmaking about disability insurance was only about eligibility for money. In contrast, as *Pegram* explained, mixed eligibility and treatment decisions do not

fit well into Congress's focus in ERISA on decisions about monetary assets. *Pegram*, 530 U.S. at 230-32.

Nor is the holding in *Pegram* limited to the situation where a treating physician is making the medical necessity determination. *Id.* at 228 (stating that the "inextricable" mixture of treatment and eligibility "is so not merely because . . . treatment and eligibility decisions are made by the same person."). The important fact for the analysis is not the identity of the particular decisionmaker within the managed care entity, but the partially medical character of the decision made. *See Land v. Cigna Healthcare of Fla.*, 339 F.3d 1286, 1288-89 (11th Cir. 2003) (considering decision made by "approval nurse"); *Cicio v. Does*, 321 F.3d 83, 88 (2d Cir. 2003) (considering decision by plan's medical director).

B. Decisions Involving Other Exercises of Professional Judgment Are Not Regulated by ERISA.

The distinction between plan administration and the exercise of professional judgment by non-fiduciaries has been understood by courts for years as an important component of ERISA preemption analysis. The federal courts have consistently rejected the notion that ERISA federalizes the regulation of professional services provided by non-fiduciaries in connection with ERISA plans. *See, e.g., Airparts Co., Inc. v. Custom Benefit Servs. of Austin*, 28 F.3d 1062, 1065 (10th Cir. 1994) (finding no ERISA preemption of state law professional negligence and other claims against outside consulting firm hired to advise trustees concerning actuarial calculations and other plan matters); *Gerosa v. Savasta & Co., Inc.*, 329 F.3d 317, 324 (2d Cir. 2003) (noting that "courts routinely find that garden-variety state law malpractice or negligence claims against non-fiduciary plan advisors, such as accountants,

attorneys, and consultants, are not preempted" and collecting cases); *Custer v. Sweeney*, 89 F.3d 1156, 1166-67 (4th Cir. 1996) (joining "unanimous body of federal law" holding that state law malpractice claims involving non-fiduciary professional services to ERISA plans are not preempted); *see also Painters of Phila. Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146, 1152-53 & n.7 (3d Cir. 1989) (noting that professional malpractice actions are analogous to the state law claims held not preempted in *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988)); *Mertens v. Kaiser Steel Ret. Plan,* 829 F. Supp. 1158, 1161-62 (N.D. Cal. 1992) (holding that where plan participants alleged that negligent provision of actuarial services caused underfunding of their pension plan, depriving them of benefits, their claims were *not* preempted by ERISA). Thus, medical judgments are not the only types of actions affecting plan participants and beneficiaries that are unregulated by ERISA and that have been held not to be preempted by ERISA.

C. The *Pegram* Framework Should Guide Preemption Analysis in Cases Involving Medical Benefits.

The analytical framework of *Pegram*—analyzing the nature of a claim based on the nature of the challenged decision—carries the same logical force in a preemption context as it did in analyzing the availability of an ERISA fiduciary breach claim in *Pegram*. Indeed, this Court has acknowledged *Pegram's* applicability in a preemption context. Two years before *Pegram*, the Pennsylvania Supreme Court considered whether ERISA preempted a state law negligence claim against an HMO. The HMO, through a reviewing doctor, had refused to authorize a patient's transfer to an out-of-network hospital for immediate emergency care. Instead, it required the patient to wait

for treatment at an in-network hospital, allegedly resulting in the aggravation of his injury. *Pappas v. Asbel* (*Pappas I*), 555 Pa. 342, 344-45, 724 A.2d 889 (Pa. 1998). After handing down its decision in *Pegram*, this Court granted the defendants' petition for certiorari in *Pappas*, vacated the judgment, and remanded "for further consideration in light of *Pegram*." *U.S. Healthcare Systems of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 530 U.S. 1241 (2000). The Pennsylvania Supreme Court then applied the *Pegram* framework to the issue of whether ERISA Section 514 preempted the state law negligence claim. It determined that the HMO's decision had involved a judgment about what constituted appropriate, safe medical care, and that, following *Pegram*, the decision's validity was properly tested through state malpractice law. *Pappas v. Asbel* (*Pappas II*), 564 Pa. 407, 419-20, 768 A.2d 1089, 1096 (Pa. 2001), *cert. denied,* 536 U.S. 938 (2002).

That *Pegram* applies to preemption cases, as this Court instructed the Pennsylvania Supreme Court, has also been understood by the lower federal courts. The Eleventh Circuit recently held that a patient could pursue a state law medical malpractice claim against his HMO based on a decision by a CIGNA "approval nurse" that the patient should receive outpatient care for an infected cat bite on his hand, rather than the inpatient care his treating doctors had recommended, allegedly leading to the amputation of his finger. *Land*, 339 F.3d at 1288-89. Applying *Pegram*, the Eleventh Circuit found that the decision was outside the scope of ERISA regulation because it was based in part on medical judgment. *Id.* at 1293-94.

The Eleventh Circuit could not have found Mr. Land's claim preempted without arrogating to the federal courts the field of state-law medical malpractice, *id.* at 1293, a drastic change not lightly made unless it was the "clear and manifest purpose of Congress." *New York State Conference*

of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995). Indeed, this Court has cautioned that preemption of state regulation in the field of health care is not to be lightly inferred, requiring a "clear manifestation of congressional purpose" to preempt such regulation. *Pegram*, 530 U.S. at 237 (citing *Travelers*). States defined standards of medical decisionmaking long before the existence of ERISA-covered plans. Because these standards of care are independent of ERISA, ERISA does not preempt actions based on application of these standards to a medical judgment based on a patient's particular "constellation of symptoms." *See Pegram*, 530 U.S. at 228; *Cicio*, 321 F.3d at 103-04.

The Second Circuit also considered *Pegram* in a preemption context in *Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003). In *Cicio*, the court of appeals found that a determination by a plan administrator's medical director regarding the experimental nature of a course of treatment may have rested on analysis of what was appropriate treatment for the particular patient. *Id.* at 91. Such a decision would be a mixed eligibility and treatment decision that could be challenged under state law after *Pegram*. *Id.* at 102 (citing *Pegram*, 530 U.S. at 229-30). The court of appeals noted its "skepticism of a line of reasoning that would draw from a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans the elimination of protective standards of professional conduct." *Id.* at 103-04 (internal quotation marks and citation omitted).[3]

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[3] The distinction between medical judgments and plan administration drawn in *Pegram* is nothing new: the same concept has long guided courts in analyzing whether state law claims were properly removed as completely preempted by ERISA. *See, e.g.*, (continued...)

IV. STATE LAW CLAIMS BASED ON THE CONSEQUENCES OF MANAGED CARE MEDICAL JUDGMENTS ABOUT THE TREATMENT OF INDIVIDUAL PATIENTS ARE NOT PREEMPTED BECAUSE THEY DO NOT DUPLICATE CLAIMS TO RECOVER PLAN BENEFITS OR ENFORCE OR CLARIFY PLAN RIGHTS UNDER ERISA § 502(a)(1)(B).

A. ERISA Does Not Preempt State Law Here Because It Does Not Duplicate the Elements of a Cause of Action Under ERISA Section 502(a)(1)(B).

In contrast to the claims here, ERISA preempts only those state laws that "duplicate[ ] the elements of a claim available under ERISA." *Rush Prudential,* 53 U.S. at 379 (discussing *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133 (1990)). In *Ingersoll-Rand*, a Texas law that provided a cause of action for wrongful discharge where the employer's

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(...continued)
Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 356-57 (3d Cir. 1995) (drawing distinction between claims attacking the "quality" of benefits provided versus claims attacking the "quantity" (e.g. erroneous withholding of benefits)); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (allowing patient to proceed with medical malpractice action against HMO based on vicarious liability for doctor's malpractice, while finding related claim based on fraudulent plan administration completely preempted by ERISA); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994) (rejecting argument that claim was completely preempted because patient received psychotherapy services pursuant to ERISA-governed plan, where suit was based not on claim for benefits but on negligent treatment and misuse of information). *Cf. Lazorko v. Pa. Hosp.*, 237 F.3d 242, 249-50 (3d Cir. 2000) (holding that quality-quantity distinction was consistent with *Pegram*).

action was alleged to be motivated by a desire to avoid paying benefits clearly duplicated the cause of action provided by ERISA Section 510, which makes it unlawful for any person to take an adverse employment action against a plan participant "for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan," and was therefore preempted. 29 U.S.C. § 1140; *see Rush Prudential*, 536 U.S. at 379 (discussing *Ingersoll-Rand*).[4]

Likewise, Section 502's preemptive force was originally brought to bear on state law claims by a participant who *could have brought at the time of filing of the lawsuit* an ERISA cause of action for past-due disability benefits, but sought to bring state law claims for damages instead. *Pilot Life,* 481 U.S. at 43-44. Those claims did not fall within the insurance savings clause of ERISA Section 514 and therefore were expressly preempted. *Id.* at 57.

B. The Section 502(a)(1)(B) Cause of Action Is Limited to Circumstances Where Benefits Are Past Due or May Become Payable in the Future.

As the Fifth Circuit correctly held, neither Section 502(a)(1)(B) nor any other subsection of ERISA Section 502 provides a cause of action arising out of injuries alleged to have been caused by the failure of an HMO to exercise ordinary care when making medical judgments. *See Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002). Causes of action under ERISA Section 502(a)(1)(B) are limited to circumstances in which a participant or beneficiary seeks

[4] Section 510 is enforced by means of an action under Section 502(a)(3). *Tolle v. Carroll Touch,* 977 F.2d 1129, 1133 (7th Cir. 1992).

"to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); *see Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 (6th Cir. 1998) (noting that ERISA Section 502(a)(1)(B) "provides a contract-based cause of action to participants and beneficiaries to recover benefits, enforce rights, or clarify rights to future benefits under the terms of an employee benefit plan"). Thus, Section 502(a)(1)(B) encompasses only those circumstances where benefits are past due or may become payable in the future. *See, e.g., Welsh v. Burlington Northern, Inc. Employee Benefits Plan*, 54 F.3d 1331, 1340 (8th Cir. 1995) (holding Section 502(a)(1)(B) empowers courts to calculate amount of benefits due); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 697 (7th Cir. 1992) (holding Section 502(a)(1)(B) supports an order for reinstatement of terminated disability benefits).

C. Neither Mr. Davila's Nor Ms. Calad's Claim Duplicates an ERISA Section 502(a)(1)(B) Claim.

Mr. Davila's and Ms. Calad's circumstances do not give rise to a cause of action under Section 502(a)(1)(B) to recover benefits due or to enforce rights under their plans because there are no benefits owing or potentially owing to them. The benefits they previously sought are no longer medically necessary, so Respondents are no longer entitled to them under the terms of their plans: Vioxx is no longer a medically appropriate treatment for Mr. Davila, and additional hospitalization following surgery is no longer medically necessary for Ms. Calad. For the same reasons, neither Respondent will have a Section 502(a)(1)(B) cause of action to clarify his or her right to these same benefits in the future. Mr. Davila can no longer take Vioxx and Ms. Calad obviously cannot undergo another hysterectomy.

Accordingly, Respondents' causes of action under the THCLA do not arise out of any circumstances within the scope of ERISA Section 502(a)(1)(B).

Ms. Calad's and Mr. Davila's cases are distinguishable from *Pilot Life* in two respects. First, as discussed above, unlike Dedeaux, neither Ms. Calad nor Mr. Davila has a current cause of action under ERISA to recover benefits due under a plan. The services previously at issue are no longer appropriate or even feasible for them. Second, their current causes of action are not based on failure to deliver the contractual plan benefits, but on the consequences of the medical judgments applied to their care. The fact that Respondents had Section 502(a)(1)(B) causes of action to enforce plan terms at some point in the past does not affect the state law causes of action currently available to them. It is true that, had Ms. Calad been able to obtain from her hospital bed counsel willing and able to seek an immediate temporary restraining order compelling Cigna to keep her in the hospital, that cause of action would have arisen under Section 502(a)(1)(B), and Ms. Calad would not have suffered the injuries that she now seeks to redress. It is also true that, had Ms. Calad had the means to pay for her additional hospital stay out of pocket, she might now have a contractual reimbursement claim under Section 502(a)(1)(B), and again would not have suffered medical injuries. Anyone would rather suffer monetary loss than physical injury, but the plaintiffs in these cases were unable to avoid the physical injuries they suffered.

Thus, as a practical matter, neither a restraining order nor out-of-pocket payment for medical treatment is available to participants in many circumstances. For this reason, it is not correct to say that because these participants had a theoretical option to pursue ERISA causes of action, however fleetingly, before they were ever injured, their state law causes of action are alternative to those now-foreclosed ERISA claims. Neither *Pilot Life* nor *Ingersoll-*

Rand dictates a contrary conclusion; rather, they merely stand for the proposition that where both ERISA and state law provide causes of action arising out of the same injury, then the preemptive force of ERISA's enforcement scheme displaces state law. Accordingly, the Fifth Circuit was correct in holding that federal jurisdiction over Respondents' claims was lacking.

CONCLUSION

The decision of the Fifth Circuit should be affirmed.

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AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, *et al.*,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICUS CURIAE*

United Policyholders is a national, not-for-profit educational organization whose mission is to educate the public, legislators and the courts on insurance issues and consumer rights, and to assist policyholders in securing prompt and fair insurance settlements.[1] The resolution of the issue presented in this case is of great importance to United Policyholders and its members because of its potential application to a wide range of laws affecting employees insured through an ERISA plan.

SUMMARY OF ARGUMENT

In *Difelice v. Aetna U.S. Healthcare,* 346 F.3d 442, 453 (3rd Cir. 2003), Justice Becker writes in concurrence, "I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime." *Id.* at 453. We submit that the root of the innumerable difficulties that have plagued the Courts is language from this Court's decision in *Pilot Life v. Dedeux,* 481 U.S. 41 (1987). Petitioners have urged this Court to extend that dicta and apply it to the circumstances here. We urge the Court to resist such an extension of *Pilot Life,* which we posit cannot withstand either scrutiny or logic in light of all that has transpired since its issuance. Indeed, *Pilot Life's* dicta has required federal courts to "struggle mightily to maintain fidelity to ERISA's expansive"[2]

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[1] United Policyholders, as *amicus curiae*, has obtained the consent of both the Petitioner and the Respondents to submit this brief. The letters of consent have been lodged with the Clerk of the Court. No counsel for any party in this case authored this brief in whole or in part, and no person or entity other than United Policyholders and its members made any monetary contribution to the preparation or submission of this brief.

[2] *Difelice* 346 F.3d at 54 (Becker, J., concurring.)

preemption while continuing to respect the rights of states to regulate insurance.

This Court has courageously remarked on prior occasions that its initial take on ERISA preemption has not always been accurate and has stepped forward to correct itself on more than one occasion. *See Kentucky Association of Health Plans, Inc. v. Miller,* 538 U.S. 329, 123 S.Ct. 1471 (2003) (making a clean break from past criteria used to determine whether a law regulates insurance within scope of saving clause); *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.*, 519 U.S. 316, 335 (1997) (ERISA preemption criteria set forth in some of the court's earlier cases, including *Pilot Life,* have "in effect been abandoned" as "a project doomed to failure" (Scalia, J., concurring); *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.,* 514 U.S. 645, 655 (1995) (recognizing that prior attempts at construing the phrase "relate to" in preemption clause "does not give us much help . . .").

United States Senior District Judge Newcomer has recently found *Pilot Life's* reasoning "unpersuasive" and "flawed" in important respects. *Rosenbaum v. Unum Life Ins. Co. of America*, 2003 WL 22078557 (E.D. Pa.). *See also Stone v. Disability Management Services, Inc.,* 288 F. Supp.2d 684, 695-96 (2003) (noting "persuasive" reasoning of *Rosenbaum*). As Justice Becker proposes, the inequities inherent in ERISA, as interpreted thus far by the courts, "cry out for clarification by Congress or, failing that, by the Supreme Court. . . . The time might be right [for the Supreme Court] to reconsider its prior rulings." *Id.* at 461, 465. And Justice Calabresi in *Cicio v. Does,* 321 F.3d 83, 106 (2d Cir. 2003), writes, " . . . the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end." (Calabresi, J. dissenting in part.)

In *Pilot Life*, this Court held that ERISA preempted a state law claim for tortious breach of contract arising from an insured ERISA disability benefits plan. The Court

found that the state law claim related to ERISA and was not saved from preemption because the Mississippi law was not aimed specifically at the insurance industry.[3] As part of the Court's analysis of the saving clause issue in *Pilot Life*, and in accordance with the views of the Solicitor General, it relied upon the structure and legislative history of the civil enforcement provisions contained in ERISA Section 502 to bolster its conclusion that Congress intended ERISA to preempt the state law remedy at issue in that action. *Pilot Life*, 481 U.S. at 51-52.

This Court has recently pointed out that *Pilot Life* does not resolve Section 502's impact on laws encompassed by the saving clause. *See Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 377 (2002) ("we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the 'reservation of the business of insurance to the States,'"); *UNUM Life Insurance Co. of Am. v. Ward*, 526 U.S. 358, 377 n.7 (1999) ("[This] case does not raise the question whether § 1132(a) provides the sole launching ground for an ERISA enforcement action"; *Pilot Life's* holding was "in the context" of a law which was not saved from preemption). Further, in *Franchise Tax Board of California v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 25 (1983), this Court clearly held that "[the saving clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to" ERISA plans. In addition, the Solicitor General has specifically pointed out that the Section 502 implied preemption analysis it presented in *Pilot Life* would not apply in a case where the state law remedy at issue was a state law regulating insurance. *Ward*, 526 U.S. 358, 377 n.7. Moreover, the

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[3] This holding in *Pilot Life* was substantially modified in *Kentucky Association of Health Plans, Inc. v. Miller,* 538 U.S. 329, 123 S.Ct. 1471, 1478-79 (2003) in which this Court made a clean break from the criteria used in *Pilot Life,* to determine whether a law regulated insurance within the meaning of the saving clause.

limited application of *Pilot Life's* Section 502 implied preemption analysis is reflected in the Court's final sentence: " . . . [W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by [the saving clause] *and therefore* is pre-empted by [the preemption clause]." *Pilot Life*, 481 U.S. at 57 (emphasis added).

In *Pilot Life* the Court notes that the remedial provision of ERISA was intended to represent the exclusive remedies available to an ERISA plan participant and thus, the state law at issue was preempted to the extent it provided a remedy not authorized under ERISA. *Pilot Life,* 481 U.S. at 54. Petitioners urge the Court to extend that reasoning to apply even if the law at issue is saved from preemption. Critically, however, the reasoning this Court used in *Pilot Life* only applies to laws of general application and does not logically extend to laws that fall within the saving clause. ERISA's clear purpose, when enacted, was to regulate pension and not insurance difficulties and the statute is clear on its face that the saving clause is not affected by Section 502. In addition, the remedies provided under ERISA are not suited to insurance disputes and there is nothing in the legislative history of ERISA which would constitute a clear and manifest intent of Congress that the saving clause be subservient to Section 502. Eminent jurists and commentators have also concluded that an extension of *Pilot Life*, as advocated by Petitioners here, strains all logic in both the interpretation of ERISA as well as its practical application. They urge this Court, as we do, to limit the effect of *Pilot Life*.

ARGUMENT

I. *All* Laws Which Regulate Insurance Are Saved From Preemption Pursuant To The Clear And Unambiguous Text Of ERISA.

ERISA was enacted as a pension reform bill intended to protect the retirement benefits of workers. *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001(b). Protecting "the continued well-being and

security of millions of employees and their dependents" was an express Congressional declaration of policy. 29 U.S.C. § 1001. ERISA comprehensively regulates pension plans. Importantly, ERISA does not comprehensively regulate the terms of non-pension employee benefit plans.[4]

In addition to its substantive provisions, ERISA includes a preemption clause, which provides that, "except as provided in [the saving clause, ERISA] . . . shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan. . . ." ERISA § 514(a), 29 U.S.C. § 1144(a). This Court has described the preemption clause as "expansive."[5] However, the preemption clause is modified by the saving clause, which declares " . . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This saving clause is "phrased with similar breadth"[6] as the preemption clause.[7]

A remedial provision is found in the same subchapter as the preemption and saving clauses. ERISA Section 502, 29 U.S.C. § 1102, contains a set of remedies available under ERISA to plan participants. Thus, on the face of the statute, all remedies available under ERISA would constitute the exclusive remedies, unless a state remedial law was saved from preemption. In that event, "*nothing* in this

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[4] *See* Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 951 (2000) (hereafter, Bogan, *Protecting Patient Rights*).

[5] *See New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 655 (1995); *Pilot Life,* 481 U.S. at 46.

[6] *Unum Life Ins. Co. of America v. Ward,* 526 U.S. 358, 363 (1999).

[7] *Ward,* 526 U.S. at 363 ("[P]re-emption is substantially qualified by an 'insurance saving clause,' . . . which broadly [saves state insurance laws]. . . ."); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 740-741 (1985) (" . . . [W]hile the general pre-emption clause broadly preempts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation").

subchapter," which by definition includes Section 502's remedial provisions "*shall* [preempt] . . . *any* . . . State [law which] regulates insurance." (Emphasis added.) Accordingly, any state law that regulates insurance, regardless of whether it creates a remedy or not is saved from preemption.

Issues of statutory construction turn on Congress' intent.[8] The Court must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."[9] Further, the Court must also presume that Congress did not intend to preempt areas of traditional State regulation.[10]

Not only is insurance an area of traditional State regulation, but Congress has specifically designated insurance as a special area of State regulation to be zealously protected from federal regulation. The McCarran-Ferguson Act provides that federal laws shall not be interpreted to supersede state laws regulating the business of insurance. 15 U.S.C. § 1012(b); *Humana, Inc. v. Forsyth,* 525 U.S. 299, 306 (1999). "Congress' 'primary concern' in enacting McCarran-Ferguson was to ensure the States' continued ability to regulate the business of insurance." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 744 n.21 (1985). And the ERISA saving clause was designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. *Id.; Ward,* 526

[8] *See Travelers*, 514 U.S. at 655.

[9] *FMC Corp. v. Holliday*, 498 U.S. 52, 57 (1990), *citing Park'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985).

[10] *See Travelers*, 514 U.S. at 655. ("We have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases . . . where federal law is said to bar state action in fields of traditional state regulation, we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress' ") (citations omitted).

U.S. at 375 n.5. Moreover, "[t]here is no discussion in [the legislative] history [of ERISA] of the relationship between the general pre-emption clause and the saving clause, and indeed very little discussion of the saving clause at all." *Metropolitan Life*, 471 U.S. at 745. This Court therefore "decline[d] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself . . . If a state law 'regulates insurance,' . . . it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause. . . ." *Id.* at 746-47.

Given the unambiguous language of the saving clause and the strong prohibitions against preemption of state insurance laws, the conclusion that a state law that falls within the saving clause is still preempted would require a clear and manifest expression of Congressional intent. Yet, as extensively discussed below, there is nothing in either the statute or the legislative history of ERISA even to suggest such an intent, let alone a clear and manifest intention.

II. A Claim That *Pilot Life's* Exclusive Remedy Analysis Should Be Extended To Laws Which Are Saved From Preemption Is Deeply Flawed.

A. The Structure Of ERISA, Including Section 502, Establishes That Congress Did Not Intend To Preempt State Remedial Laws That Are Saved From Preemption.

In *Pilot Life*, this Court stated that Congress intended that all claims arising from an ERISA-governed employee benefit plan which fall within the ambit of ERISA Section 502 must be pursued exclusively through ERISA.[11] This Court founded its conclusion on two factors: (1) the structure of ERISA itself and (2) ERISA's legislative history and, in

[11] *Pilot Life*, 481 U.S. 41.

particular, reference in that history to the preemptive scope of Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 185. Regarding the structure of ERISA, the Court held that the ERISA remedies represented a comprehensive enforcement scheme, which, in light of ERISA's broad preemption clause, was intended to be exclusive. The Court determined that parties were not "free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life,* 481 U.S. at 54.

It is certainly true that Section 502 contains a comprehensive enforcement scheme. However, the saving clause is a fundamental element of that comprehensive scheme. One cannot merely presume that, because Section 502 is comprehensive, that it was intended to prevail over the saving clause in the event of a conflict. Surely Congress was aware that, in order to accomplish such a result, it only need have included in the saving clause language providing that all such laws were saved "except laws providing remedies other than those set forth in Section 502." Or it could simply have prefaced the saving clause with, "except as provided in Section 502." Or it could have invoked a multitude of other ways to make itself clear. Indeed, if there was such a clear and manifest intent of Congress to have Section 502 trump Section 514, it is hard to fathom why Congress did not include such an easy clause in the language of the statute itself.

We must also ask ourselves the question, "If we presume that Congress intended to save from preemption all laws regulating insurance – even laws providing additional remedies – could Congress have expressed its intent more clearly than it did in the statute itself?" The short answer is that it would be hard to imagine language that was more explicit. The statute itself provides that the saving clause supersedes both the preemption clause and the remedial provisions in the event of a conflict.

While the Court's conclusion in *Pilot Life* can be applied to generally applicable state law remedies, or more importantly, to laws affecting pension benefits, the same is not true of laws which fall within the specific Congressionally-carved

exception, which saves laws regulating insurance. Congress did not "reject" remedies specifically provided for within the confines of the saving clause. On the contrary, such laws were specifically saved, not rejected. Further, the saving clause is fundamental to the structure of the Act. It provides that " . . . *nothing* in this subchapter shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Not only are the remedies contained in the same subchapter as the saving clause (remedies in 29 U.S.C. § 1132 saving clause in 29 U.S.C. § 1144), but the saving clause is in the very same statute as the preemption clause (29 U.S.C. § 1144).

The Solicitor General, upon whom this Court relied in *Pilot Life,* has also questioned this Court's suggestion in *Pilot Life* that ERISA Section 502 was intended to be exclusive of all state law remedies. In his amicus brief to the Court in *Ward*, he suggested that this Court should reconsider this part of the *Pilot life* opinion. Br. of United States as *Amicus Curiae* in *Ward*, No. 97-1868 (November 1998) at 7, 20-25.

> We recognize that *Pilot Life* has been read to preclude even state law causes of action arising under laws that "regulate[ ] insurance." That portion of *Pilot Life's* rationale is, however, in significant tension with the text of the insurance savings provision and was unnecessary to *Pilot Life* 's holding that the law at issue there was not in any event an insurance regulation within the meaning of that provision.
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> We do not question [the exclusive remedy] reasoning in *Pilot Life* as a general matter. Unquestionably, "Congress intended § 502(a) to be the exclusive remedy for rights guaranteed under ERISA." [Citations omitted.] And it is certainly true that, outside the context of state laws that "regulate insurance" within the meaning of the ERISA insurance savings clause, that exclusivity of the Section 502 civil enforcement provisions

also appropriately informs the Court's understanding of the scope of ERISA preemption where a plaintiff brings a cause of action under state law that "relates to" an ERISA plan. [Citation omitted.] Congress, in short, clearly intended the remedial provisions of ERISA to be exclusive of any generally applicable state-law remedies related to ERISA plans. [Citations omitted.]

It does not follow, however, that ERISA Section 502 should inform the preemption inquiry to the same extent with respect to a state-law cause of action or remedy that specifically "regulates insurance" as it does with respect to one of general applicability. In that situation, Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanctions to enforce that substantive law, *see, e.g., Metropolitan Life*, 471 U.S. at 734 (suit by state Attorney General against insurer of ERISA plans to enforce provision of state insurance law), especially where the causes of action provided under Section 502 itself are not suited to that purpose.

The savings clause states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). "[T]his subchapter" includes Section 502, which has been construed to provide exclusive remedies under ERISA, as well as the preemption provision itself, Section 514(a). Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be "construed" to relieve or exempt any person from "any law" of a State that regulates insurance. Thus, the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state-mandated benefits laws and other prescriptive measures that do so.

This Court gave effect to the facially unrestricted scope of the insurance savings clause in *Metropolitan Life*, when it "declin[ed] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it," and concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected an interpretation of the [insurance] saving clause . . . that saved from preemption 'only state regulations unrelated to the substantive provisions of ERISA'"). In addition, the force of the savings provision's express terms is reinforced by the Court's frequent recognition – particularly in recent cases – that ERISA's preemption provisions must be read against the background of the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." [Citations omitted.]

Ward Br. at 20, 22-25 (footnotes omitted).

As the Solicitor General has carefully explained, the structure of ERISA and, in particular, Section 502 cannot serve as the clear and manifest intent of Congress required to override the clear terms of the saving clause itself. Moreover, a further look into the structure of the remedial provisions discloses powerful evidence that Congress did *not* intend the remedial provisions to prevail over the saving clause.

To the extent ERISA is implicated, the disputes here – and in nearly all the matters impacted by *Pilot Life* – are, at bottom, insurance disputes between insureds and his/her insurance company (or HMO). Logic would dictate that such disputes be resolved in a lawsuit between an insured on the one hand and the insurer or HMO on the other hand. However, ERISA's remedial provision is not set up that way. There is a third party, which is inexplicably inserted into the middle of the dispute. This is the

ERISA plan itself. ERISA requires that an action to recover benefits must be brought against the plan as an entity. "Any money judgment ... against an employee benefit plan shall be enforceable *only against the plan* as an entity and shall not be enforceable against any other person. . . ." 29 U.S.C § 1132(d)(2) (emphasis added). Thus, ERISA does not permit a suit against the insurer, which owes the benefits. "ERISA permits suits to recover benefits only against the Plan as an entity." *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985); *Garratt v. Knowles*, 245 F.3d 941, 949 (7th Cir. 2001). Because of this, courts have repeatedly held insurers are not proper parties to an action under ERISA and have repeatedly dismissed actions filed against insurers.[12]

In the context of a welfare benefit plan in which the only benefit is the purchase of insurance, such a procedures makes no sense in a dispute between an insured and an insurer. A suit against the plan is, at best, a very odd procedure. The plan is not really an entity at all. It is a creation of ERISA and may exist without any documentation, any employees, any office or any funds.[13] Indeed, it can be created as a matter of law without the expressed intention or documentation of anyone.[14] Why would Congress insist that an action for insurance benefits must be

[12] *See, e.g., Everhart v. Allmerica Financial Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 958 (2002); *Gibson v. Prudential Ins. Co. of N. Am.*, 915 F.2d 414, 417 (9th Cir. 1990); *Roeder v. Chemrex, Inc.*, 863 F. Supp. 817, 828 (E.D. Wis. 1994); *Cohen v. Equitable Life Ass. Soc. of the United States*, 196 Cal.App.3d 669, 672-73 (1987).

[13] *See, e.g., Gaylor v. John Hancock Mutual Life Ins. Co.*, 112 F.3d 460, 463-65 (10th Cir. 1997) (ERISA plan determined from surrounding circumstances); *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207, 1213-15 (11th Cir. 1999) (same); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (written plan not necessary to establish ERISA plan); *Marshall v. Bankers Life & Cas. Co.*, 2 Cal. 4th 1045, 1054, 832 P.2d 573 (1992) (same).

[14] *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984).

filed against an entity, which exists in name only, but, in reality, has no assets or personnel? Indeed, in these circumstances, all of the claims decisions are delegated by contract to the insurance company and thus an action by the claimant against the insurer is the obvious manner of resolving such disputes. State courts have been resolving exactly that kind of insurance claim for over 200 years. The "plan" really has no role whatsoever in resolution of the dispute. Yet, under ERISA's structure, in order to obtain benefits, an insured must proceed against the plan and, presumably, if a judgment is entered against the plan, force a second action by the plan against the insurer to obtain the amount of the judgment from the insurer. This is a highly cumbersome and illogical method of obtaining insurance benefits. It is hard to imagine why Congress would impose such a burdensome procedure on a claim that is between an insured and an insurer.[15]

An action solely against the plan does make sense in the case of pension plans and self-funded plans, which are not subject to ERISA's saving clause. These plans are subject to ERISA's substantive provisions regarding vesting and financing. An action directly against such plans makes sense because those plans actually have funds and personnel administering those funds. Thus, ERISA's requirement that a monetary award can only be satisfied

[15] Some courts have held, without statutory authority, that the administrator who controls the plan may be sued. *See, e.g., Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997); *Rosen v. TRW, Inc.*, 979 F.2d 191, 193 (11th Cir. 1992). While insurers are not generally administrators as defined by ERISA (29 U.S.C. § 1002(16)(A)(i)) some courts have still suggested that an insurer may be sued if the claimant can establish that the insurer was the administrator. *See Moran*, 536 U.S. at 363, n.3; *Everhart v. Allmerica Financial Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 958 (2002). Nonetheless, it is highly improbable that the drafters of ERISA would have left an insured's right to sue an insurer dependent on the question of whether the insurer functioned as an administrator – an issue the appellate courts still have not resolved or clarified nearly 30 years after ERISA was enacted.

against the plan, thereby immunizing the administrators from personal liability, makes perfect sense. However, ERISA provides no substantive protections for welfare plans. It, therefore, made sense for Congress to permit these substantive protections to be enforced in state actions directly against insurers through the saving clause. It would make little sense for Congress to have intended that insureds jump through the complicated hoops designed to apply effectively to funded plans, but not designed to work in connection with unfunded plans. Similarly, there is no reason for Congress to have left substantive regulations to the states, but preempted the states' procedures to enforce those rights.

Further evidence of this is found in this Court's jurisprudence. ERISA was intended to "safeguard employees from the abuse and mismanagement of *funds* that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash,* 490 U.S. 107, 113 (1989) (emphasis added). Congress was concerned with the need of *employers* to be able to rely on uniform laws, rather than individual state laws. *Moran*, 536 U.S. at 378-79. Once again, this has applicability to funded plans, but not to disputes among third-party insurers and insureds. That liability does not rest with the employer, but with the insurer. In any event, ERISA specifically contemplates that disuniformities for national insurance plans will necessarily occur as a result of the saving clause. *Ward*, 526 U.S. at 376, n.6.

Moreover, this Court has repeatedly made clear that insurance enforcement mechanisms and laws regulating claims practices are at the core of McCarran-Ferguson and thus ERISA's saving clause. *Kentucky Association*, 123 S.Ct. at 1478, n.3 ("notice-prejudice" rule discussed in *Ward* fell within saving clause because it directly affected insurer's claims processing function.); *Ward,* 526 U.S. at 374 n.5 (stating that "laws regulating claims practices . . . [are included] in catalogue of state laws that regulate insurance."); *Metropolitan Life,* 471 U.S. at 744 (type of state regulation encompassed by McCarran-Ferguson, includes "enforcement").

Thus, a careful look at the structure of the remedial provisions of ERISA shows, if anything, that the act was intended to be enforced exactly as written – i.e., that all state laws regulating insurance, including remedial laws, are saved from preemption. This is entirely consistent with ERISA's purpose. ERISA imposes substantive regulations on, and provides direct actions against, funded plans. Yet, it does not provide substantive regulations against unfunded welfare plans and thus permits direct state actions against the parties ultimately responsible for the payment of benefits. This is also consistent with the long-standing principles of field preemption, whereby Congress does not intend to completely preempt a field without inserting substantive federal regulations in place of the existing state regulations.

B. Nothing In The Legislative History Supports A Conclusion That Congress Intended To Preempt State Remedial Laws That Are Saved From Preemption.

Pilot Life also discussed ERISA's legislative history. Yet, as set forth at length below, there is nothing in the legislative history of the Act to support a conclusion that ERISA was intended to preempt remedies that were explicitly saved from preemption. The principle piece of legislative history referred to in *Pilot Life* is the Conference Report's reference to the Labor-Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 185. 481 U.S. at 55. The *Pilot Life* Court found this statement to reflect Congress' intent to compare ERISA's preemptive effect with the powerful preemptive force of Section 301 of the LMRA. *Id*. Once again, this may apply with regard to laws of general applicability or laws relating to funded pension benefits; however, it has no bearing with respect to a law that falls within the saving clause. The LMRA has no saving clause and thus is not comparable legislation when addressing a law that is specifically saved from preemption. Indeed, this Court has made this very point.

This Court has repeatedly pointed out that the saving clause is just as broad as the preemption clause. *Ward*, 526 U.S. at 363; *Metropolitan Life*, 471 U.S. at 733. Thus, the remedial clause cannot serve to trump the saving clause simply because of reference in the legislative history to the LMRA.

> The phrasing of § 502 [ERISA's remedial provision] is instructive. . . . It does not purport to reach every question relating to plans covered by ERISA . . . *Furthermore, § 514(b)(2)(A) of ERISA [the savings clause] makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans.* With important, but express limitations, it states that 'nothing in this subchapter shall be construed to relieve any person from any law of any State which regulates insurance, banking, or securities.' *In contrast*, § 301(a) of the LMRA applies to all 'suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce . . . or between any such labor organizations.'

Franchise Tax Board of State of California v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 25 (1983) (emphasis added).

Even the *Pilot Life* decision makes this clear. In citing to the legislative history, the Court quoted one of the bill's sponsors, Senator Williams, as follows: *"[W]ith the narrow exceptions specified in the bill*, the substantive and enforcement provisions of the conference substitute are intended to preempt the field. . . ." 481 U.S. at 46 (emphasis added). Manifestly, the saving clause is the principal exception.[16] Moreover, Senator Williams' statement, as well

[16] Reference in Senator Williams' remarks to the "narrow" exception is "far too frail [to] support" a restricted reading of the saving clause. *Metropolitan Life*, 471 U.S. at 746.

as those of the other sponsors of the bill,[17] were made in the context of the intended purpose of the Act as pension reform legislation.

Once again, the Solicitor General is in agreement with this view. The Solicitor General concluded its discussion in its *Ward* brief by pointing out that this Court's reference in *Pilot Life* to the portion of ERISA's legislative history relating to Section 301 of the LMRA "does not bear directly on the preemption of a state law cause of action or remedy that 'regulates insurance.' That is because LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision." *Ward* Br. at 25.

III. Recent Court Decisions Contain Repeated Requests That This Court Reconsider Its Dicta In *Pilot Life*.

Ever since its issuance, *Pilot Life* has led to repeated expressions of angst among courts faced with its tragic inequities. *See Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1005 (9th Cir. 1998), *cert. denied*, 120 S.Ct. 170 (1999) ("Although this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy"); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1271 (10th Cir. 1996) ("Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm [the grant of summary judgment to the insurer]"); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) ("The result ERISA compels us to reach means the Corcorans have no remedy, state or federal, for what may have been a serious mistake"); *Andrews-Clarke v.*

[17] Further, while these comments were persuasive to this Court in the context of a law of general application, they are "of little help in analyzing § 514(b)(2)(A) for . . . the saving clause is broad on its face and specific in its reference." *Metropolitan Life*, 471 U.S. at 746 n.24.

Travelers Ins. Co., 984 F. Supp. 49, 52-54, 65 (D. Mass. 1997) ("The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. . . . Under traditional notions of justice, the harms alleged . . . should entitle [her] to some legal remedy. . . . Nevertheless, this Court had no choice but to pluck [her] case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers . . . , to slam the courthouse doors in her face and leave her without any remedy. . . . Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers . . . from potential liability for the consequences of their wrongful denial of health benefits . . . [ERISA] has gone conspicuously awry from its original intent. . . . Does anyone care? Do you?" (footnotes omitted); *Florence Nightingale Nursing Serv., Inc. v. Blue Cross & Blue Shield of Alabama*, 832 F. Supp. 1456, 1457 (N.D. Ala. 1993), *aff'd*, 41 F.3d 1476 (11th Cir. 1995); *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (N.D. Ala. 1988); *see also* Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 Santa Clara L. Rev. 105 (concluding that saving clause saves state law insurance remedies); Bogan, *Protecting Patient Rights*, *supra* note 4, at 996-1002 (contending that Supreme Court dicta in *Pilot Life* not consistent with statutory text and legislative intent); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 Harvard J. on Legis. 35, 38 (1996) ("It is a rich irony that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws.") (footnote omitted).

In *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003), Justice Calabresi, in dissent, writes, " . . . the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to

the same end." Justice Calabresi suggests that ERISA's drafters

> . . . nicely "balanc[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." [cite]
>
> Or so Congress and ERISA beneficiaries fairly could have hoped. What they got instead was the Supreme Court's "Trail of Error," in which the Court lumped consequential and punitive damages into the misleading category of "extracontractual relief," [cite] and disallowed both by dint of an anachronistic (and historically false) law/equity distinction said to be implicit in Congress's provision for "appropriate equitable relief" in § 502(a)(3).

321 F.3d at 107.

Justice Calabresi urges the Court to reconsider its rulings limiting the form of relief available under ERISA. However, the crux of the problem is *Pilot Life*, as it is the lower courts' interpretation of that opinion which has divested claimants of the right to pursue claims directed specifically at insurance abuses and which would provide for compensatory damages.

In *Rosenbaum v. UNUM Life Ins. Co.*, *supra*, the Court looked carefully at *Pilot Life* and the language in *Moran* which related to *Pilot Life*. It found the Court's discussion of Congressional intent to be "flawed in three important respects." It failed to apply the fundamental rule of statutory construction that courts must presume that a statute means what it says (*Rosenbaum* at *7-8) and ERISA's saving clause is clear on its face that "nothing," including Sections 502 and 514, can affect state laws saved from preemption. *Id.*

> Other than the obvious requirement that the law must regulate insurance, Congress placed no other requisites or restrictions on the laws saved from preemption under ERISA's saving clause. In this regard, Congress' intent was clear, it wanted all state laws which regulate insurance to be

exempt from preemption under ERISA. The *Pilot Life* and *Rush* holdings present an implied Congressional intent which flatly contradicts this express intent. Rather than allowing any state law which "regulates insurance" to survive ERISA preemption, this implied intent adds an additional requirement, that is, the law must not offer a remedy which is not listed under § 502(a). The problem with such a requirement is that the Courts have taken an implied intent, which was derived by questionable means, and have interpreted that implied intent to overrule Congress' express intent, as reflected in the saving clause. . . .

* * *

Finally, the *Pilot Life* and *Rush* Opinions disregard the fundamental presumption against implied preemption. "[T]he historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." [cite] Here, the clear and manifest purpose of Congress was memorialized in the saving clause, which provides for state regulation to be excluded from preemption under ERISA when it "regulates insurance." To find to the contrary would supplant Congress' express intent and, in the process, would violate the spirit of the Tenth Amendment, "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." U.S. Const. Amend. X

Rosenbaum at *7-9.

Justice Becker in *Difelice* also wrote in concurrence to urge this Court to reconsider its ERISA holdings, including specifically its broad preemption holding. His language is important and powerful. He notes that ERISA and Section 514 preemption have become

> . . . virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided.
>
> * * *
>
> This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights. . . .
>
> * * *
>
> The unavailability of extracontractual damages has effects that are perverse. . . . it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see, Pilot Life,* 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

Difelice, 346 F.3d at 456-462.

Justice Becker believes that the bar to extracontractual damages has led to an ERISA "preemption nightmare" and suggests that the Supreme Court revisit its preemption analysis. He explains that ERISA's legislative history, upon which *Pilot Life* is based, is hardly clear, and that the preemption clause was inserted at the last minute

and with little Congressional debate. *Id.* at 466. He concludes:

> The evidence suggests that Congress did not carefully consider whether the scope of preemption should reflect the different degrees of federal regulation of pension plans and welfare benefit plans. *See* Fisk, *The Last Article about the Language of ERISA Preemption?,* 33 Harv. J. on Legis. at 56. In my view, section 514(a)'s broad preemptive scope is sensible with regard to pension plans, for federal law fully displaces state law and provides vesting, requirements, minimum funding requirements, and a raft of other employee safeguards. However, to me, it makes much less sense with respect to welfare plans. As discussed *supra,* Congress exempted welfare benefit plans from most of ERISA's substantive regulations, such as its vesting and minimum funding requirements.
>
> As I see it, it is unlikely that Congress intentionally created this so-called "regulatory vacuum," in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute. The more likely explanation is that Congress merely intended to create minimum safeguards to protect the financial integrity of welfare benefit plans while stopping short of federalizing the entire remedial regime, especially in light of what was a workable state-law remedial system. Congress's failure to distinguish explicitly between pension and welfare benefit plans in § 514(a) is understandable, for, as explained above, the managed care plans that wreak havoc with § 514(a) as it relates to welfare benefit plans did not exist when ERISA was enacted. There is no evidence that Congress envisioned the current situation.

Id. at 467.

Undoubtedly these eminent jurists have gone to great lengths to speak out because of their firm belief that *Pilot Life* is a flawed decision and that the repeated tragic consequences of that decision are so innumerable and have gone so far as to cry out for this Court's intervention. They recognize, as we discuss below, that the legislative history is clear that Congress did not intend that ERISA preempt state laws which are saved from preemption and that to do so makes little sense.

IV. ERISA's Legislative History Is Unequivocal In Disclosing That The Act Was Intended To Regulate Pension Benefits And Was Not Intended To Impact The Field Of Insurance.[18]

As this Court has recognized, ERISA was a massive legislative undertaking. *Pilot Life,* 481 U.S. at 44. Yet, the briefing regarding the legislative history before the Court in *Pilot Life* was nearly non-existent. This Court relied on the last two pages of the Solicitor General's short brief supporting the grant of certiorari. *Id.* at 52. However, none of the other briefs in the case discussed the legislative history at all. Thus, no one sought to assist the Court in presenting the lengthy legislative history, which conflicts with that presented in the Solicitor General's original brief. Moreover, as noted above, the Solicitor General has since changed his view on the proper interpretation of ERISA's legislative history. When one views that history in context, it is plain that there is nothing in that history to support an implied Congressional intent which is contrary to the plain words of the statute itself.

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[18] *See generally* Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1976) [hereinafter "Legislative History"]; Special Comm. on Aging, U.S. Senate, 98th Cong., The Employment Retirement Income Security Act of 1974: The First Decade 1-25 (Comm. Print 1984) [hereinafter "The First Decade"].

The legislative history discussed herein is carefully and extensively set forth in greater detail in Bogan, *Protecting Patient Rights, supra,* 74 Tul. L. Rev. 951; *See also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism,* 48 U. Pitt. L. Rev. 427, 437-457 (1987).

ERISA was the direct outgrowth of the explosion in private pension plans during the middle of the last century. The number of employees covered by such plans grew from approximately 4 million in 1940 to over 30 million by 1973.[19] The estimated assets held by such plans during this same period grew from $2.4 billion to $150 billion.[20] With this explosive growth came a similarly expansive growth in the abuses of such funds.[21] In addition, the enormous accumulation of such funds exerted a major impact on the country's financial markets.[22] This explosion occurred without the benefit of any effective federal or state regulation.[23]

In 1954, at the request of President Eisenhower, Congress undertook an extensive study of the private pension industry.[24] This study disclosed abuses, including incompetent management of pension funds, looting, embezzlement, kickbacks, excessive administration costs and imprudent investment practices.[25] In response, Congress enacted the

[19] *See* S. Rep. No. 93-127, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4839-40, and in 1 Legislative History, *supra* note 18, at 589.

[20] *See* H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 2350; The First Decade, *supra* note 18, at 5; 4641, and in 2 Legislative History, *supra* note 18, at 5; James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 24 (1978).

[21] *See* 120 Cong. Rec. 29,934 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (statement of Sen. Javits); The First Decade, *supra* note 18, at 6 n.22 (citing congressional hearings on abuse in pension plan administrations); *see also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, *supra* note 18, at 443-45 (referring to the many abuses in employee pension plans listed in ERISA's legislative history).

[22] *Id*; H.R. Rep. No. 93-533, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 18, at 2350.

[23] *See* note 17 *supra*.

[24] *See* S. Rep. No. 85-1440, at 2-11 (1958), *reprinted in* 1958 U.S.C.C.A.N. 4137.

[25] *Id*. at 4137-47

Welfare and Pension Plans Disclosure Act in 1958.[26] This law merely required the disclosure of certain financial information to the employees and did not provide any meaningful regulation of the funds themselves.[27]

This legislation was wholly ineffective.[28] Consequently, in 1962 President Kennedy appointed a special task force to study the problem.[29] The task force concluded that further federal regulation of private pension plans to include mandatory minimum vesting and funding requirements was necessary and that further study was required on other issues.[30] Significantly, the task force specifically did not investigate or consider any reforms of nonpension plans, such as health insurance plans.[31] In response to these concerns, New York Senator Jacob Javits

[26] Pub. L. No. 85-836, 72 Stat. 997 (1958) (repealed 1974).

[27] *See* H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 18, at 2351; *Malone v. White Motor Corp.*, 435 U.S. 497, 507 (1978) (plurality opinion).

[28] *See* S. Rep. No. 93-127, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4841; H.R. Rep. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 18, at 2351.

[29] *See* President's Comm. on Corporate Pension Funds and Other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans, at vii-viii (1965) [hereinafter "President's Committee Report"]; *see also* The First Decade, *supra* note 16, at 8-10 (describing the formation of the committee and its findings).

[30] *Id*.

[31] *See* President's Committee Report, *supra* note 27, at iv ("Although the area of investigation assigned to the Committee included welfare plans as well as retirement programs, the President's memorandum specifically raised questions about issues which arise primarily from retirement plans. Other types of welfare plans, such as health and insurance plans, make important contributions to the economic security of American workers; they do not, however, have the impact of pension plans on accumulation of savings, labor mobility, and similar matters touched upon by the President. Consequently, the Committee has confined its efforts to an inquiry into private employee retirement plans (i.e. excluding plans for self-employed persons) without any extensive study of other types of welfare plans.").

introduced legislation in 1967 to create federal funding and participation requirements for private pension plans.[32] This led to further Congressional investigations and eventually ERISA. In 1970, the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare began a three-year study "undertaken to ascertain the need for statutory protections for workers' pension programs and to formulate appropriate corrective legislation."[33] Like the previous investigations, the subcommittee's hearings disclosed a morass of abusive practices resulting in the loss of retirement benefits to employees as the result of inadequate funding, mismanagement and unreasonable vesting requirements.[34] It agreed with President Kennedy's task force and recommended comprehensive regulation of the pension industry.[35] Shortly thereafter, Senator Javits introduced Senate Bill 4. It stated, "[t]he purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems which have been determined by the Senate Subcommittee's comprehensive study of such plans."[36] A corresponding House bill was also introduced.[37]

[32] *See* 113 Cong. Rec. 4650-53 (1967) (statement of Sen. Javits); *see also* 120 Cong. Rec. 29,933-34 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (remarks of Sen. Javits) (recounting his continued efforts to reform the private pension and welfare system).

[33] *See* S. Rep. No. 92-634, at 1 (1972); *see also* 119 Cong. Rec. 30,003 (1973), *reprinted in* 2 Legislative History, *supra* note 18, at 1598 (statement of Sen. Williams).

[34] *See* H.R. Rep. No. 93-533, at 5-8 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4639, 4643-46, and in 2 Legislative History, *supra* note 18, at 2355.

[35] *See* 120 Cong. Rec. 29,935-44 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4748 (remarks of Sen. Javits).

[36] S.4, 93d Cong. (1973); *see* S. Rep. No. 93-127 (1973), at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4838, and in 1 Legislative History, *supra* note 18, at 587.

[37] *See* H.R. 2, 93d Cong. (1973), *reprinted in* 1 Legislative History, *supra* note 18, at 3.

These bills were sent to their appropriate committees, which issued their own reports. Each of these reports concerned themselves solely with abuses in and the consequent need for regulation of private pension plans.[38] The Senate Committee on Labor and Public Welfare report states:

> The provisions of S.4 are addressed to the issue of whether American working men and women shall receive private pension plan benefits which they have been led to believe would be theirs upon retirement from working lives. It responds by mandating protective measures and prescribing minimum standards for promised benefits. The purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems . . . .[39]

The report states that "[t]he principal issues affecting the vital and basic needs for legislative reform involve consideration of the essential elements of pensions: (1) 'vesting,' (2) 'funding,' (3) 'reinsurance,' (4) 'portability' and (5) 'fiduciary responsibility and disclosure.'"[40] Similarly, the House Committee on Education and Labor report states that the "primary purpose of the bill is the protection of individual pension rights" and that the legislation was designed to: (1) establish minimum fiduciary standards for retirement plans, (2) provide for enforcement and public disclosure of finances, (3) improve the equitable

[38] *See* S. Rep. No. 93-127, at 1-36, *reprinted in* 1974 U.S.C.C.A.N. at 4838-89, and in 1 Legislative History, *supra* note 18, at 587-622; H.R. Rep. No. 93-533, at 1-28, *reprinted in* 1974 U.S.C.C.A.N. at 4639-70, and in 2 Legislative History, *supra* note 18, at 2348-75; 120 Cong. Rec. 29,933-35 (1974), *reprinted in* 3 Legislative History, *supra* note 18, at 4746-51 (remarks of Sen. Javits).

[39] S. Rep. No. 93-127, at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 18, at 587.

[40] S. Rep. No. 93-127, at 8-11, *reprinted in* 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 18, at 594-97 (emphasis omitted).

character and soundness of private pension plans by requiring (a) appropriate vesting and (b) minimum funding standards, and (4) guarantee the adequacy of the plan's assets prior to termination.[41]

ERISA's legislative history is unequivocal that it was intended as a pension reform bill. In describing ERISA, Senator Javits said, "[T]he pension reform bill is the greatest development in the life of the American worker since social security. For the first time in our history most workers will be able to truly retire at retirement age and live decently on their social security and private pensions."[42] Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, described his committee's study which lead to ERISA. "This study clearly established that too many workers, rather than being able to retire in dignity and security after a lifetime of labor rendered on the promise of a future pension, find that their earned expectations are not to be realized."[43] In the House, one of the principal proponents, Representative Dent, described ERISA's purpose in this way: "[W]e started out with only one aim in view and that was to give a pension participant his entitlements under the contract of the pension plan he belonged to."[44] The record is filled with tragic examples of workers deprived of pension benefits after 30, 40 and 50 years of employment because they were a few days short of vesting before retiring, the company was sold or went bankrupt, or because the

[41] H.R. Rep. No. 93-533, at 1, 17-18, *reprinted in* 1974 U.S.C.C.A.N. at 4655-56, and in 2 Legislative History, *supra* note 18, at 2348, 2364-65.

[42] Legislative History, *supra* note 18, at 4747 (Remarks of Sen. Javits).

[43] Legislative History, *supra* note 18, at 4733 (Remarks of Sen. Williams).

[44] Legislative History, *supra* note 18, at 4665 (Remarks of Rep. Dent).

employer could not afford to pay the promised retirement benefits.[45]

While this Court has referred to ERISA as a "comprehensive and reticulated statute,"[46] it is so only with respect to pension plans, and the Court's description of the Act as such a statute originated in the context of pension cases.[47] The Act substantially regulated pension plans but contained virtually no meaningful regulation of insurers or insurance "plans."

What is clear from this long and extensive legislative history and the statute itself is that the exclusive concern of Congress in passing ERISA was to address abuses in the pension field. Not a single insurance concern is expressed anywhere in the legislative history. Instead, Congress expressly saved all insurance regulation to the States. This Court has endorsed this view, noting that the broad preemption clause was added at the last minute, that there is no legislative history discussing the relationship between the saving clause and the general preemption clause, and that there is a "complete absence of evidence" to support a narrow reading of the saving clause. *Metropolitan Life*, 471 U.S. at 745-46 n.21. As one commentator who has extensively reviewed ERISA's legislative history reports,

> . . . ERISA's legislative history is remarkable . . . for what it does not contain. ERISA's legislative

[45] *See, e.g.*, Legislative History *supra* note 18, at 4749-50 (Remarks of Sen. Javits on "Why Pension Reform Is Needed), (4791-96 (Remarks of Sen. Bentson), (4664-65) (Remarks of Rep. Thompson), (4710) (Remarks of Rep. McClory); *Interim Report of Activities of the Private Welfare and Pension Plan Study, Subcommittee On Labor of the Committee on Labor and Public Welfare*, S. Rep. No. 92-634, 92d Cong., 2d Sess. (1972) at 67-90.

[46] *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981); *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980).

[47] *Id.*

history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans.

* * *

There is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of nonpension benefit plans, or of any specific concern with the management of nonpension plan assets. Further, ERISA's legislative history fails to disclose any concerted investigation of any complaints about nonpension benefits, such as inadequate health care, accident, death or disability coverage, or problems with health, life, or disability benefits claims. In short, Congress just was not dealing with nonpension benefit plans when it enacted ERISA.

Bogan, *Protecting Patient Rights, supra,* note 4 at 972, 976-77.

CONCLUSION

ERISA's statutory history as pension reform legislation is unequivocal. Its language saving any state law regulating insurance is unambiguous and, because ERISA was not intended to regulate insurance, it fails to provide a meaningful remedy to resolve insurance disputes. As many Courts and commentators have now requested, this Court should revisit the wisdom of its dicta in *Pilot Life* and disapprove the analysis set forth therein.

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IN THE

Supreme Court of the United States

CIGNA HEALTHCARE OF TEXAS, INC.,
Petitioner,

v.

RUBY R. CALAD, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF THE COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL ASSOCIATION OF COUNTIES, AND INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether § 502(a) of ERISA preempts negligent treatment claims filed under the Texas Health Care Liability Act.

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INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county, and municipal governments and officials throughout the United States.[1] *Amici* have a compelling interest in the issue in this case: whether ERISA preempts state laws regulating the medical treatment decisions of HMOs and Utilization Review Organizations (UROs).

The States have long protected the health and safety of their citizens by regulating the practice of medicine through both licensing requirements and tort liability. Under traditional systems of health care financing, insurers either paid or denied payment for completed medical procedures. Over the last thirty years, however, the provision of health care has become predominately subject to cost-control mechanisms such as utilization review. HMOs and UROs now routinely assert both the expertise and authority to override physicians' decisions as to the appropriate course of medical care while a patient's treatment is ongoing. These HMO and URO decisions can have a dramatic impact on patients' health with at times fatal results. States such as Texas have accordingly recognized the practical reality that utilization review frequently involves the practice of medicine, and that HMOs and UROs should be accountable for their negligent medical decisions.

CIGNA's broad reading of ERISA section 502(a) would create a regulatory void by rendering HMOs and UROs unaccountable for negligent treatment decisions. It would also impose on patients and their survivors the costs of injuries caused by the negligent treatment decisions of HMOs and

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[1] The parties have consented to the filing of *amicus* briefs in this case and have filed blanket consent letters with the Clerk of the Court. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *amici* or their members, has made a monetary contribution to the preparation or submission of this brief.

UROs. Because such conduct is clearly outside the scope of ERISA, but squarely within the regulatory authority of the States, *amici* submit this brief to assist the Court in its resolution of this case.

SUMMARY OF ARGUMENT

1. The Court has repeatedly recognized the States' long-standing authority to protect the health and safety of their citizens by regulating health care. The Court has made clear that 'in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000). Thus, there is a strong presumption that ERISA does not preempt the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003.

Contrary to CIGNA's contention, ERISA section 502(a) does not overcome this presumption. Congress enacted the remedies of section 502 to address benefit denials under the then-predominate fee-for-service system. Under that system, insurers either paid or denied payment for completed medical procedures. Most significantly, utilization review organizations did not assert authority—as they do now—to override physicians' decisions as to the appropriate course of medical care while treatment was ongoing.

It is entirely appropriate for Texas to exercise its police powers to protect the health of its citizens by recognizing that utilization review decisions frequently involve the practice of medicine. The Texas act addresses the diffusion of authority for medical treatment decisions that has occurred with the widespread adoption of utilization review.

THCLA imposes liability on an HMO only for failing "to exercise ordinary care when making health care treatment decisions." Tex. Civ. Prac. & Rem. Code § 88.002(a). The Act does not impose any obligation on an HMO "to provide . . . treatment which is not covered by the health

care plan." *Id.* § 88.002(d). Calad's THCLA claim does not present a dispute over the terms of the plan. Her claim is not for "improper processing of a claim for benefits," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987), but rather for the independent tort which occurred when (as she alleges) CIGNA overrode her treating physician's decision, substituted its own judgment as to the course of necessary medical treatment, and caused her injury.

Neither ERISA nor DOL's regulations impose any substantive standard of conduct applicable to HMOs and UROs in making treatment decisions. *See Pegram*, 530 U.S. at 232-37. CIGNA's position would thus create a regulatory void with the perverse result that those patients who defer to an HMO's supposed medical expertise and do not challenge its treatment decision are remediless when that decision causes them injury. The Court should reject CIGNA's attempt to transfer accountability for, and the costs of, its negligent medical decisions onto its patients. Such a result is irreconcilable with ERISA's policy "to protect the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b).

2. None of CIGNA's policy arguments support extending ERISA preemption to immunize HMOs and UROs from liability for their negligent treatment decisions. Contrary to CIGNA's assertion, ERISA section 502(a)'s remedies of a suit for reimbursement or a suit for injunctive relief are not always effective. Most patients typically do not have the financial means to pay for a procedure in advance. Indeed, that is why they join their employer's health plan. Similarly, whether a particular medical treatment is medically necessary is a highly complex and fact-intensive issue. Thus, the costs of litigating a suit for injunctive relief are likely to be substantial. Just as most people lack the financial resources to pay for treatment in advance, they also cannot underwrite a suit for injunctive relief. Moreover, while under ERISA, the

court, "in its discretion may" award attorney's fees "to either party," 29 U.S.C. § 1132(g)(1), few attorneys will undertake such a costly and time-consuming litigation given that if they do not prevail, they will receive no compensation for their time and expenses. Finally, ERISA's remedies are totally inadequate where a patient defers to the HMO/URO's decision regarding appropriate treatment and subsequently suffers injury.

Finally, CIGNA and its *amici* refute their own contention that subjecting HMOs and UROs to tort liability for their negligent treatment decisions "will vastly increase the costs of providing benefits" and result in a reduction in health care coverage for workers. CIGNA Br. 48. As CIGNA and its *amici* acknowledge, only a very small percentage of claim denials involve the issue of whether treatment was medically necessary. Beyond the fact that the number of potential lawsuit-triggering decisions is low, not every wrongful denial of medically necessary treatment will result in a lawsuit. Notwithstanding an HMO/URO's negligent treatment decision, a patient may not suffer an injury and even those who are injured will not necessarily sue. Finally, the litigation experience of several large non-ERISA plans suggests that such lawsuits will have only a minimal impact on plans' costs.

ARGUMENT

ERISA SECTION 502(a) DOES NOT PREEMPT NEGLIGENT TREATMENT CLAIMS FILED UNDER THE TEXAS HEALTH CARE LIABILITY ACT

The court of appeals properly rejected CIGNA's contention that ERISA section 502(a), 29 U.S.C. § 1132(a), completely preempts claims brought under the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem. Code §§ 88.001—88.003 (reproduced in CIGNA Pet. App. 56a-63a). As this Court has recognized, health insurers—whether health maintenance organizations (HMOs), managed care

organizations (MCOs), or utilization review organization (UROs)—frequently do far more than make simple benefit eligibility determinations. *See Pegram v. Herdrich*, 530 U.S. 211, 228-29 (2000).

"[A] great many and *possibly most* coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition. . . ." *Id.* at 228 (emphasis added). Rather, they involve the "when-and-how question" of "whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case." *Id.* at 229. In short, they are medical judgments which are well beyond the scope of Congress's regulatory purpose in enacting ERISA. *See id.* at 236 ("ERISA was not enacted . . . in order to federalize malpractice litigation").

As explained below, Texas's creation of a statutory cause of action for persons injured by a medical insurer's negligence in overriding a physician's judgment as to the required course of treatment and prescribing different and inadequate treatment, is not a suit "to recover benefits" or "to enforce [one's] rights under the terms of [a] plan." 29 U.S.C. § 1132(a)(1)(B). Such a suit does not challenge an ERISA administrator's interpretation of the plan, but rather its medical judgment regarding the course of required treatment.

Because this case involves an exercise of the State's historic powers to regulate the practice of medicine and the insurance industry, ERISA no more preempts Calad's state-law claims than it does state regulations requiring that HMOs and MCOs employ properly credentialed physicians and nurses in providing health care. *Cf. De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997). Indeed, adoption of CIGNA's position would create the perverse result that HMOs, MCOs, UROs, and insurers are immunized

from damages liability for injuries caused by their negligence in making medical decisions in administering an ERISA medical plan, but not when they administer employee benefit plans that are not subject to ERISA, *see* 29 U.S.C. § 1003(b), or when they administer a health insurance contract generally. The judgment of the court of appeals should therefore be affirmed.

A. Neither Section 502(a) Nor ERISA's Statutory Purpose Manifest Congress's Intent To Preempt State-Created Causes Of Action Against HMOs, MCOs, and UROs For Failing To Exercise Ordinary Care In Making Health Care Treatment Decisions

The Court has repeatedly held that "the historic police powers of the State include the regulation of matters of health and safety." *De Buono*, 520 U.S. at 814 (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985)). *See also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002) (upholding state independent review statute against ERISA preemption challenge). Moreover, the Court has further recognized that a State can "regulate insurance as one way to regulate the practice of medicine" and that such regulation is "permissible under ERISA." *Id.* (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985)). Indeed, the Court has explained "that regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care." *Id.* (citing *Pegram*, 530 U.S. at 236).

This Court has thus made clear that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237. CIGNA thus "bear[s] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state

law.'" *De Buono*, 520 U.S. at 814 (quoting *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995)). That burden is even greater where, as here, a state law also regulates the practices of insurers, *see* Tex. Civ. Prac. & Rem. Code § 88.002, an area which ERISA expressly saves from preemption. *See* 29 U.S.C. § 1144(b)(2)(A) ("nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance"); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

CIGNA nonetheless argues that Section 502(a), ERISA's civil enforcement provision, completely preempts Calad's claim under THCLA because it provides the exclusive remedial scheme for the participants and beneficiaries of ERISA plans to challenge benefit denials. *See* CIGNA Br. 11-15 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)). *See Pilot Life*, 481 U.S. at 52 (holding that section 502 is "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting the improper processing of a claim for benefits")). According to CIGNA, "[t]he real question is whether [Calad's] THCLA claim seeks to remediate the violation of a right already protected by ERISA." CIGNA Br. 24.

Most troubling, CIGNA asserts that the "the injuries [Calad] seeks to remedy follow only from the fact that CIGNA, she says, improperly refused to cover the expenses of the additional time in the hospital." *Id.* According to CIGNA, because "[i]t is undeniable that Calad could have brought a § 502(a)(1)(B) action to obtain exactly what her THCLA claim asserts was wrongfully denied her—the payment of the expenses of the additional hospital stay," her claim "seeks additional remedies for an assertedly improper denial of her hospital stay benefit, [and] is completely preempted under *Pilot Life*." *Id.* at 24-25.

The Court should reject CIGNA's attempt to immunize itself from accountability when it overrides a treating physician's judgment and substitutes it own negligently made medical decision as to the appropriate course of a patient's medical care. True enough, some claims that arise out of benefit disputes—such as the refusal to pay a submitted claim or authorize a procedure in advance—are properly deemed to be within the scope of section 502(a)(1)(B). But many disputes between patients or survivors and HMOs/UROs are not susceptible to resolution under section 502(a)(1)(B), especially where, as here, HMOs and UROs assert the medical expertise and authority to make medical treatment decisions. Because ERISA provides no substantive standard applicable to medical treatment decisions, *Pilot Life*, which holds only that a state law claim "asserting improper processing of a claim for benefits" is preempted, 481 U.S. at 52, is not controlling.

As a general matter, CIGNA's approach creates the paradoxical result that patients such as Calad who accept an HMO's judgment as to the course of appropriate treatment are left utterly remediless for the injuries they suffer when that judgment turns out to have been negligently made. Moreover, CIGNA's view takes no account of the reality that most patients lack the requisite knowledge and training in medicine to challenge an HMO's determination of medical necessity. As CIGNA's *amici* acknowledge, "[a]t a moment of need an insured patient, while the ultimate 'consumer' of the care, typically lacks . . . the expertise to make informed decisions for himself." Br. *Am. Cur.* AAHP-HIAA *et al.* 9. Yet under CIGNA's view, these same patients are denied any remedy for their injury when they rely on their HMO's judgment that a particular course of treatment is not medically necessary, while HMOs, MCOs and UROs, which assert the expertise to override the judgments of treating physicians, are shielded from liability for the harm caused by their negligent medical decisions.

The foregoing acknowledgement of CIGNA's *amici* is especially relevant to Calad's case. As anyone who has undergone major surgery knows, following the procedure a patient is prescribed pain medication that affects their decision-making ability. Indeed, discharge instructions commonly advise the patient against making any important business or legal decisions following surgery. *See, e.g.*, Veterans Administration Medical Center, Houston, Texas, *Outpatient Surgery Handbook—Discharge Planning,* available at http://www.houston.med.va.gov/handbooks/op_surgery/recovery.html (visited Jan. 19, 2004) ("you should not . . . make important decisions until at least one day following surgery or longer"); Temple University Hospital, *Patient Information—Information for Day Surgery Patients*, available at http://www.health.temple.edu/tuh/General_Information/day_of_procedure.html (visited January 7, 2004) ("You should not . . . make any legal decisions for 24-48 hours following your discharge."). A patient is thus typically in no condition to evaluate the correctness of a benefits denial that results in a discharge and to determine whether to pursue an immediate administrative appeal of a denial of a longer hospital stay.[2] Nor for that matter is a patient then capable of

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[2] CIGNA argues that Calad had available several remedies to appeal CIGNA's discharge order. *See* CIGNA Br. 42-44. CIGNA emphasizes Calad's failure to invoke these remedies upon being informed by CIGNA in pre-authorization that absent certain symptoms she was entitled to only a one-day stay in the hospital under its discharge protocol. *See id.* at 43-44.

These arguments are unpersuasive for several reasons. First, surgery is an extremely stressful event for the patient. Prior to surgery, most patients are under too much stress to do battle with their HMO. Second, a patient has no basis for knowing before the procedure whether they will have post-operative symptoms warranting a longer stay.

Moreover, following a major procedure a patient is in no condition to make a reasoned decision as to whether to challenge a discharge determination. Nor, even assuming that Calad was in sufficient condition to challenge the discharge, is it clear that an appeal of CIGNA's discharge

making a rational decision as to whether to stay in the hospital, pay for the additional days out of their own pocket, and later bring a suit for reimbursement under section 502(a)(1)(B).[3] *See* Pet. Br. 43. Again under CIGNA's view, that patient is barred from any remedy when CIGNA has overridden a physician's judgment as to the course of appropriate treatment and thereby caused injury to the patient.

CIGNA's argument is undercut by the fact that Congress enacted the remedies of section 502 in 1973 to address benefit denials under the then-predominate "fee-for-service" system. *Cf. Pegram*, 530 U.S. at 218. Under that system, insurers

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determination could have been adjudicated in a timely fashion prior to her discharge. *See* CIGNA Br. 42-43 (discussing DOL regulations which were not in existence at time of Calad's procedure).

[3] That DOL's regulations require a plan to allow the patient's physician to represent the patient in an appeal of an adverse benefits determination, *see* 29 C.F.R. § 2560.503-1(b)(4), does not support a contrary conclusion. It is unclear whether a physician has a legal "'duty to advocate' with a patient's health care plan when it denies or delays treatment the physician has requested." *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 281 (3d Cir. 2001). In *Pryzbowski*, the Medical Society of New Jersey filed an *amicus* brief arguing that physicians have no such duty, and the court of appeals expressly noted "that physicians, under existing New Jersey law, have no duty to advocate on behalf of their patients to an HMO or any health insurance plan for the timely approval of benefits." *Id.* at 282.

Nor given the workload of physicians, and the view of some physicians that certain insurance companies systematically and unreasonably deny claims, is it surprising that physicians would oppose the creation of any such obligation. *Cf.* Tom Graham, *Docs Feel Hassled, Too*, Washington Post, Dec. 23, 2003, at HE2 (noting that "'less than honorable patterns of paying claims' . . . recently led insurance giants Aetna and Cigna to settle federal class actions suits filed by doctors"); Dan Christensen, *In Doctors' National HMO Suits, Aetna and Cigna Decide To Settle*, Palm Beach Daily Bus. Rev., Dec. 15, 2003, at 10 (noting doctors' allegation that "under the banner of cost containment, . . . Aetna, . . . Cigna and other managed care companies conspired to cheat them out of billions of dollars by denying or manipulating claims to wrongly reduce or delay payments").

either paid or denied payment for completed medical procedures. And utilization review organizations did not assert authority—as they do now—to override physicians' decisions as to the appropriate course of medical care while treatment was ongoing. *Cf.* Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 Yale L.J. 1297, 1303 (1994); *see also* Jeffrey E. Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. Rev. 731, 742 (1999) ("Between 1982 and 1985, twenty-seven percent of U.S. companies introduced utilization review into their health plans. . . . In 1996, approximately ninety percent of employers used some type of utilization review in their health plans.").

Contrary to CIGNA's views, it is entirely appropriate for Texas to exercise its police powers to protect the health of its citizens by recognizing that utilization review decisions frequently involve the practice of medicine. Texas has acted to address the diffusion of authority for medical treatment decisions that has occurred with the wide-spread adoption of utilization review systems. As one commentator explains:

> Although third-party payers claim that their decisions are benefits determinations and not medical decisions, the effect of their decisions is to determine what treatment a patient should receive. Because most patients cannot afford treatment without reimbursement from the plan and most physicians cannot afford to provide care without reimbursement, a determination that treatment is not appropriate and, therefore, will not be paid for by the plan, is in effect a decision not to provide care or to provide alternative care. A UR decision is, therefore, akin to and frequently has the effect of a medical decision by a treating physician. This similarity is highlighted by the fact that UROs use health care providers, such as physicians and nurses, to make UR determinations and to design UR guidelines.
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> * * *

> Not only are UROs interposing themselves into medical decisionmaking by determining what is medically necessary, they are also changing the physician standard of care by affecting physician decisionmaking and, therefore, physician practice. UROs evaluate a treating physician's plan of care using their own medical experts. Moreover, they "recommend" alternative courses of treatment with the knowledge that most patients will follow their directions. The arrangements between third-party payers, UROs, and physicians, therefore, distribute medical authority among several actors.

Shuren, *supra*, at 747-48.[4]

It is true, as the Court recognized in *Pegram*, that many utilization review decisions do not involve the practice of medicine and are thus properly characterized as simple benefits determinations. *See* 530 U.S. at 228-29. But as *Pegram* further recognized, some UR decisions clearly do involve the practice of medicine. This is amply demonstrated in various cases where HMOs and UROs have overridden the treating physician's diagnosis and plan of care and substituted their own opinion of what constitutes necessary medical treatment in a given case. *See id.* at 229.

For example, in *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286 (11th Cir.), *petition for cert. filed*, No. 03-649 (Oct. 28, 2003), the treating physicians diagnosed a CIGNA HMO member as having a serious non-localized infection, which required hospitalization "for aggressive intravenous

[4]Another authority likewise explains:

> [T]hird party payors, in the context of managed-care arrangements, often make decisions that we would normally consider to be medical ones. Utilization review companies evaluate a treating physician's plan of care using their *independent medical expertise*; in addition, they suggest alternative courses of treatment with the knowledge and expectation that most patients will follow their prescriptions.

Frankel, *supra*, at 1320 (emphasis added).

antibiotic treatment and constant monitoring and assessment of his infection to determine whether surgery or modified antibiotic treatment would be necessary." *Id.* at 1288. Shortly after the patient was admitted, a CIGNA approval nurse reviewed the treating physicians' plan of care. *See id.* While the CIGNA nurse agreed with the physicians' prescription of intravenous antibiotic therapy, she reached a contrary conclusion as to treatment, deciding that Land had "a localized infection that did not require hospitalization." *Id.* She therefore disapproved Land's hospitalization and he was discharged. *See id.* Following his discharge, Land's condition deteriorated; he subsequently underwent multiple surgeries and ultimately had his index finger amputated. *See id.* at 1288-89.

In CIGNA's view, its reviewing nurse's action was merely a determination of Land's benefits under his health insurance plan. *See id.* at 1290. According to CIGNA, Land has no remedy against it notwithstanding that its reviewing nurse clearly made a medical error when she substituted her own diagnosis of a localized infection for the treating physicians' conclusion that Land had a more serious infection that required inpatient monitoring.

Likewise, in *Roark v. Humana, Inc.*, a patient required continued use of a vacuum-assisted closure device (VAC) and daily home nursing care to treat a leg wound. *See* 307 F.3d 298, 303 (5th Cir. 2002). Notwithstanding that the patient's primary care physician had informed the HMO "that without the VAC and home nursing care, Roark could lose her leg," the HMO "periodically delayed VAC and home nursing treatment" and eventually "cancelled home nursing altogether." *Id.*[5]

[5] According to the Fifth Circuit, Roark had repeatedly challenged the HMO's attempts to terminate VAC treatment and home nursing care. *Id.* at 303. Her pursuit of these remedies did not deter the HMO from its determination to terminate medically necessary treatment.

Within three months, Roark "developed a serious infection" that resulted in the amputation of her leg. *Id.* at 303-04. Following the procedure, the HMO "again denied [Roark] VAC treatment that may have helped heal the amputation wound." *Id.* at 304. Less than a year later, Roark was forced to undergo "an additional amputation treatment on her leg." *Id.*

Again, under CIGNA's view, Congress has immunized the HMO from liability in Roark's case notwithstanding the serious injury she incurred as a result of its decision to override the medical treatment prescribed by her treating physician. And again, the HMO is unaccountable for its medical decision notwithstanding that it asserted both expertise and authority to override a treating physician's prescription of a course of medically necessary treatment.

Similarly, in *Isaac v. Seabury & Smith, Inc.*, 2002 WL 1461710 (S.D. Ind. 2002), a patient being treated at the M.D. Anderson Cancer Center, one of the nation's leading cancer facilities, was diagnosed by her oncologist as having chronic myelogenous leukemia. The oncologist contacted the URO seeking "Urgent Review" of the patient's need for a bone marrow transplant. *Id.* at *1. In his written diagnosis, the oncologist stated that the patient's condition was "unstable." *Id.* The oncologist further concluded that neither chemotherapy nor radiation was likely to cure the patient's illness and that "'[t]he only documented therapy capable of curing this disease is bone marrow transplantation from a histocompatible donor.'" *Id.* (citation omitted).

Nonetheless, the URO denied coverage on the ground that the prescribed procedure was not "medically necessary." *Id.* Although four weeks later the URO modified the denial and gave "conditional approval" for the procedure, *id.* at 2, the patient died two weeks later before the transplant could be performed. *See id.*

CIGNA's position is that an ERISA plan patient should, upon being denied necessary treatment, pursue an administrative appeal and, if it is denied, "arrange to pay for the procedure outside the plan, and then file a § 502(a)(1)(B) action seeking reimbursement for the expenses." CIGNA Br. 43. Alternatively, CIGNA maintains that the patient can sue under § 502 for an injunction to enforce plan terms. *See id.* at 27-31, 42-44. For most patients, neither choice provides an effective remedy.

Few patients have the financial means to pay for a bone marrow transplant or the treatments necessary to cure other serious illnesses and conditions. Indeed, that is why people purchase health insurance or join their employer's health plan in the first place.

Nor, in most cases, does a suit for an injunction provide a realistic remedy. Given the "highly fact-intensive" nature of the issues, with the likely need for expert testimony on what care is medically necessary and complies with the prevailing standard of care, "[t]he costs of such suits are likely to be immense." *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 459, 458 (3d Cir. 2003) (Becker, J., concurring). While under ERISA "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party," *see* 29 U.S.C. § 1132(g)(1), it does so "if at all, only after the action concludes." *DiFelice*, 346 F.3d at 458 (Becker, J., concurring). Just as most people lack the financial resources to pay for treatment in advance, they also cannot underwrite a suit for injunctive relief. And few attorneys will undertake such costly and time-consuming litigation given that if they do not prevail, they will receive no compensation for their time and expenses. Thus, in most instances involving treatment decisions, section 502's remedies are, as Judge Becker concluded, "entirely illusory." *Id.* at 459 (Becker, J., concurring).

CIGNA's contention is thus simply an attempt to transfer accountability for, and the costs caused by, its negligent medical decisionmaking from itself onto its patients. Acceptance of this view would lead to the perverse result that those patients who defer to an HMO's supposed medical expertise and do not challenge the HMO's decision regarding appropriate treatment—that is, "most patients," Shuren, *supra*, at 748—are left without a remedy when that decision causes them injury. The Court should reject this inequitable contention, which is totally contrary to ERISA's core purpose of protecting "the interest of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

Indeed, the Court has frequently dismissed similar assertions that federal law preempts state law where, as here, doing so would result in the denial of any effective remedy. The Court has rejected the proposition "that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984); *cf. Medtronic, Inc. v. Lohr*, 518 U.S. 470, 487 (1996) (rejecting preemption claim that would "have the perverse effect of granting complete immunity from design defect liability to an entire industry that, in the judgment of Congress, needed more stringent regulation" to protect health and safety).

To similar effect is *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656 (1954). There the Court dismissed the contention that federal law preempted a state tort action based on conduct that also constituted an unfair labor practice under the LMRA, 29 U.S.C. § 187. While acknowledging that Congress had authorized preventive relief against unfair labor practices, as well as a limited damages remedy for illegal secondary boycotts, the Court declined to hold state tort actions preempted. It reasoned that "[t]o do so will, in

effect, grant petitioners immunity from liability for their tortious conduct." 347 U.S. at 664.

The Court explained that "[t]o the extent that Congress prescribed preventive procedure against unfair labor practices . . . the [LMRA] excluded conflicting state procedure to the same end." *Id.* at 665. The Court held, however, that "[t]o the extent . . . Congress has not prescribed procedure for dealing with the consequences of tortious conduct already committed, there is no ground for concluding that existing criminal penalties or liabilities for tortious conduct have been eliminated." *Id.* The Court concluded that to hold state law preempted would "mean that where the federal preventive . . . procedures are impotent or inadequate, the offenders, by coercion of the type found here, may destroy property without liability for the damage done." *Id.* at 669.

The Court's LMRA jurisprudence is particularly instructive given that "§ 502(a) [of ERISA] was modeled on the exclusive remedy provided by § 301 of the [LMRA]." *Pilot Life*, 481 U.S. at 52. Although *United Construction Workers* did not involve § 301, "even under § 301 [the Court has] never intimated that any action merely relating to a contract within the coverage of § 301 arises exclusively under that section." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 n.28 (1983). As the Court further stated, "a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract." *Id.* (citation omitted).

Rather, what section 301 preempts is a "state-law claim [whose resolution] is *substantially dependent* upon the analysis of the terms of an agreement made between the parties in a labor contract." *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 220 (1985) (quoted in *Pilot Life*, 481 U.S. at 55) (emphasis added). But like a battery claim that arises in the context of a labor dispute, Calad's claim for negligent

medical treatment is not "substantially dependent upon the analysis of the terms" of her health care benefit plan.

THCLA imposes liability only for failing "to exercise ordinary care when making health care treatment decisions." Tex. Civ. Prac. & Rem. Code § 88.002(a). The statute defines a "health care treatment decision" in relevant part as "a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." *Id.* § 88.001(5). Furthermore, the statute expressly states that it "create[s] no obligation on the part of the . . . [HMO] to provide to an insured or enrolled treatment which is not covered by the health care plan of the entity." *Id.* § 88.002(d).

Calad's THCLA claim does not present a dispute over the terms of the plan. She was entitled to remain in the hospital as long as the stay was medically necessary. *See* CIGNA Br. 3. The underlying dispute is whether, in light of Calad's post-operative condition, CIGNA's decision that she be discharged one day after major surgery complied with the "duty to exercise ordinary care" as defined by "the prevailing practices and standards of the medical profession and community." Tex. Civ. Prac. & Rem. Code §§ 88.002(a); 88.001(1). Her claim is not one for the "improper processing of a claim for benefits," *Pilot Life*, 481 U.S. at 52, but rather for the independent tort which occurred when (as she alleges) CIGNA overrode her treating physician's decision, substituted its own judgment as to the course of necessary medical treatment, and caused her injury.

Neither ERISA nor DOL's regulations impose any substantive standard of conduct applicable to HMOs and UROs in making treatment decisions. *See Pegram*, 530 U.S. at 232, 236; 29 C.F.R. § 2560.503-1. It is thus implausible to suggest that ERISA section 502 should be construed to completely preempt Calad's claim and thereby create a regulatory void. Indeed, acceptance of CIGNA's contention would "have the perverse effect of granting complete immunity" from mal-

practice liability when a patient's health care is provided by an ERISA plan but not when a patient's care is provided by a plan that is not subject to the statute. *See Medtronic*, 518 U.S. at 487. Given ERISA's purpose of protecting plan participants and beneficiaries, *see* 29 U.S.C. § 1001(b), it would be an especially problematic to leave ERISA plan members who have been injured by the negligent treatment decisions of HMOs and UROs worse off than persons covered by non-ERISA plans. As there is no evidence that this was Congress' intent, the Court should reject CIGNA's preemption argument.

B. CIGNA's Policy Arguments Are Unpersuasive And Do Not Justify Immunizing HMOs, MCOs and UROs From Liability For Negligently Made Medical Decisions

In their effort to extend ERISA preemption to immunize themselves from the consequences of negligent medical decisions, CIGNA and its *amici* make several policy arguments. *See* CIGNA. Br. 42-49; Br. *Am. Cur.* AAHP-HIAA at 19-26. To believe CIGNA and its *amici*, allowing patients to bring tort suits against HMOs and UROs would have dire consequences for the employer-based system of health care. As explained below, these contentions do not withstand scrutiny. Moreover, they are patently insufficient to justify "insulat[ing] HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries." *DiFelice,* 346 F.3d at 453 (Becker, J., concurring).

First, CIGNA contends that ERISA already "provides numerous protections for ERISA plan beneficiaries' rights." CIGNA Br. 42. But as explained at pp. 15-16, *supra*, those remedies are not always meaningful.[6] Most signifi-

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[6] *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp.2d 296 (E.D. Pa. 2003), demonstrates the erroneousness of petitioner's regime. There, a URO rejected the recommendations of four different physicians that

cantly, those remedies are totally inadequate where a patient defers to the HMO/URO's decision regarding appropriate treatment and subsequently suffers injury. It is perverse to transfer the costs of negligent treatment decisions from entities that assert the expertise to override medical judgments onto patients who typically lack such expertise. *See* Br. *Am. Cur.* AAHP-HIAA at 9 ("an insured patient . . . typically lacks . . . the expertise to make informed decisions for himself").

Moreover, adoption of CIGNA's position would "create[] a monetary incentive for HMOs to mistreat . . . beneficiaries, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess." *DiFelice*, 346 F.3d at 453-54 (Becker, J., concurring). Under CIGNA's proposed scheme, "if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith." *Id.* at 459. As Judge Becker has further explained, "[a]ny rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all." *Id.*[7] Indeed, not even the prospect of paying

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Nguyen needed a particular procedure. *Id.* at 299-300. While Nguyen pursued several administrative appeals, the URO repeatedly failed to forward to the reviewer critical evidence (CT scan films) which supported Nguyen's need for the procedure. *See id.* at 300-01. While ultimately, Nguyen was forced to bring a section 502 claim, the insurer's bad faith rendered the administrative appeals meaningless.

[7] Contrary to CIGNA's assertion, *see* CIGNA Br. 44-46, the fact that in some instances (such as a self-funded plan) an HMO/URO does not bear the financial risk of treatment costs does not justify immunizing them from liability for negligent treatment decisions. Even under these arrangements the HMO/URO may have a financial incentive to deny treatment as the HMO/URO's performance of its contract may be judged by whether it has held the line on costs. In any event, CIGNA's market

compensatory damages exists to deter HMOs and UROs from the negligent making of treatment decisions. *See id.*

CIGNA further asserts that "imposing the medical malpractice tort regimes of the various states on employee health benefit coverage decisions will vastly increase the costs of providing benefits." CIGNA Br. 48. Putting aside that liability under THCLA attaches only to treatment decisions, *see supra* p. 18, the litigation experience of non-ERISA plans amply refutes this contention.

In the late 1990s, the Henry J. Kaiser Family Foundation[8] commissioned a study of three large non-ERISA health care plans: those of the California Public Employees Retirement System (CalPERS), Los Angeles Unified School District (LAUSD), and State of Colorado Employee Benefit Plan.[9] It found that "[a]ll three programs reported very low rates of litigation ranging from 0.3 to 1.4 cases per 100,000 enrollees per year." Coopers & Lybrand, L.L.P., *Impact of Potential Changes to ERISA: Litigation and Appeal Experience of CalPERS, Other Large Public Employers and a Large California Health Plan* 5 (Henry J. Kaiser Family Foundation 1998). Based on an assumed "average cost per case for litigation of $100,000" and CalPERS's estimated cost of $10,000 for an administrative hearing, the study found that "the direct monthly cost per enrollee related to litigation ranged between $0.03 and of $0.13." *Id.* at 6.

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incentives approach does not justify imposing on patients the costs of injury caused by an HMO/URO's negligent treatment decisions.

[8] The Henry J. Kaiser Family Foundation is a non-profit private foundation that studies health care issues.

[9] At the time of the study, CalPERS had about one million members in its health care plan; the LAUSD had 70,000 members, and Colorado had 30,000. *Impact of Potential Changes to ERISA*, *supra*, at 2. Eighty percent of CalPERS's and Colorado's health plan members were enrolled in managed care; one hundred percent of LAUSD's members were enrolled in HMOs or HMO point of service plans. *See id.*

The Kaiser Study also examined the litigation rate of a large California insurer/HMO before and after the Court's *Pilot Life* decision. *See Impact of Potential Changes to ERISA*, *supra*, at 6-7. Before *Pilot Life*, the insurer/HMO had a litigation rate of 3.2 cases per 100,000 enrollees; after *Pilot Life*, the litigation rate was 2.4 cases. *Id.* These figures, however, included "both group and individual coverage cases," the latter not being subject to ERISA. *Id.* at 7. The study further determined that even at the higher litigation rate, and assuming a $100,000 average cost per claim, the litigation cost would only be "$0.27 per person per month." *Id.* at 8. Thus, contrary to the predictions of CIGNA and its *amici*, subjecting HMOs and UROs to liability is not likely to have more than a minimal effect on the costs of ERISA plans.

Indeed, CIGNA and its *amici* refute their own prediction of "vastly increase[d] . . . cost[s]." CIGNA Br. 48. As *amici* AAHP-HIAA acknowledge, "there is no reason to think that there is a widespread problem of plan participants wrongly denied coverage for necessary care, and then subjected to bad medical outcomes . . . . MCOs deny only a small percentage of coverage claims, and only a few of those denials are based on a failure to meet pre-authorization criteria." Br. *Am. Cur.* AAHP-HIAA 22; *see also id.* at 22 n.47 ("Of the less than 2% of plan enrollees who are initially denied coverage, only 6% of denials resulted from failure to meet pre-authorization criteria") (citation omitted); CIGNA Br. 46 (asserting that the percentage of "claims denied because they are not medically necessary represent" is less than "2.8 percent of the total claims submitted").

Whether or not these "numbers . . . support assertions that HMOs pursue profits by denying claims without attention to their merit," CIGNA Br. 46,[10] they clearly do not support

[10] This contention cannot, of course, be evaluated without knowing the nature and costs of the treatments being denied. *See, e.g., Cicio v. Does*, 321 F.3d 83, 88 (2d Cir.) (denying approval of double stem cell transplant for patient with multiple myeloma), *petition for cert. filed*, No. 03-69 (July 11, 2003); *Isaac*, 2002 WL 1461710, at *1-2 (denying approval of bone marrow transplant for patient with myelogenous leukemia). Undoubtedly, many of the denials involve the most costly treatments.

CIGNA's contention that allowing ERISA participants and beneficiaries to sue HMOs and UROs for negligent treatment decisions "will vastly increase the costs of providing benefits, all but guaranteeing" less health care for workers. *Id.* at 48. Beyond the fact that the number of potential lawsuit-triggering decisions is low, not every wrongful denial of medically necessary treatment will give rise to a lawsuit. Notwithstanding the HMO/URO's negligent treatment decision, a patient may not suffer an injury. And those who suffer injury because of an HMO's or URO's tortious treatment will not necessarily sue.[11] In short, even when state law remedies such as THCLA are available, the number of lawsuits is likely to be low and, as the Kaiser Study

[11] There is substantial evidence that many patients injured by medical malpractice do not sue. *See* Carole Roan Gresenz, *et al.*, *A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries* 5 (1999), available at http://www.rand.org/publications/IP/IP184/index.html. According to the Harvard Medical Practice Study, "very few (approximately 3 percent) of the patients whom physician reviewers deemed to be victims of negligence in the course of their hospitalizations brought malpractice claims." *Id.* (citing Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990)).

While "many of the patients [in the Harvard study] . . . fully recovered from the injury within six months," *id.*, another study "found that only 33 percent of patients who were *seriously injured* by negligent care filed medical malpractice claims." *Id.* (emphasis added) (citing D. M. Studdert, *et al.*, *Suing for Medical Malpractice in Utah and Colorado in 1992* (unpublished manuscript)). Furthermore, because medical malpractice litigation is typically conducted on a contingency fee basis, "medical malpractice plaintiff attorneys are highly selective in deciding what claimants to represent because of the high costs of this specialized litigation and the risk of not obtaining compensation." *Id.*

indicates, such lawsuits will have only a minimal effect on the cost of health care.

CIGNA acknowledges that utilization review systems "have not been perfected . . . and may never be." *Id.* at 47. Indeed, as long as the only liability an HMO faces if it makes an erroneous treatment decision is the cost of the care it should have provided, it will have little incentive to improve its UR systems to reduce erroneous decisions. Moreover, where a URO does not bear the cost of care, under CIGNA's theory, it will have no incentive to improve its systems. Finally, whether utilization review systems produce better health care outcomes overall than do other methods of health care delivery and financing, *see id.*, that does not justify pre-empting state law remedies and allowing HMOs and UROs to shift the costs of their negligent medical treatment decisions onto patients.

ERISA does not provide a substantive standard applicable to HMO and URO medical treatment decisions. *See Pegram*, 530 U.S. at 236. Such regulation is, however, squarely within the realm of the States' longstanding authority to protect their citizens' health and safety. *See id.* at 237. The Court should therefore reject CIGNA's contention that ERISA preempts Calad's state-law medical negligence claim.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent, No. 02-1845.

CIGNA HEALTHCARE OF TEXAS, INC.,
and CIGNA CORPORATION,

Petitioners,

v.

RUBY CALAD,

Respondent, No. 03-83.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF *AMICUS CURIAE* OF CALIFORNIA CONSUMER HEALTH CARE COUNCIL, CONGRESS OF CALIFORNIA SENIORS AND CALIFORNIA COALITION FOR ETHICAL MENTAL HEALTH CARE IN SUPPORT OF THE RESPONDENTS.

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QUESTION PRESENTED

Can ERISA, a statute enacted to protect employees, be used by health insurers and health plans, such as HMOs, MCOs and other health insurance companies, to deny those employees the right to recover against those companies if those companies wrongfully deny employees the medical treatment to which those employees are entitled?

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STATEMENT OF STANDING

Pursuant to Rule 37, a blanket letter of consent from the parties to this appeal has been filed with the Clerk of the Court permitting this brief on behalf of *amici*.[1]

INTEREST OF AMICUS

Founded in April 1995 and incorporated as a California non-profit public benefit corporation in April 1996, the **California Consumer Healthcare Council ("CCHCC")** is a grassroots, volunteer-governed and operated public benefit corporation concerned with protecting the interests of health care consumers throughout California and the United States. The CCHCC is committed to establishing and enhancing health care systems that work well for all Americans. CCHCC advocates, in all available forums, to protect of health care consumers from dangerous, deceptive, dishonest, unlawful or unfair practices. Ensuring that laws designed to protect consumers from improper acts and practices of health insurers and health plans are fully enforced is central to CCHCC's purpose. It is dedicated to preserving and obtaining, through the courts, the power to hold MCOs, HMOs and other insurers accountable for their conduct.

CCHCC has among its constituents, health care consumers affected by limitations on available redress. A diverse range of policyholders from across the United States regularly communicate with CCHCC regarding health insurance claims. Because CCHCC monitors both marketplace developments and policyholders' real life experiences, the organization provides topical information to courts throughout the country via the submission of *amicus curiae* briefs in cases involving insurance principles

[1] Pursuant to Rule 37.6, no counsel for either party has authored this brief in whole or in part and no person or entity has made a monetary contribution to the preparation or submission of this brief.

relating to health care that are likely to impact large segments of the public.

The issues addressed in this case impact health care regulation in California and across the United States and are of immediate and substantial concern to this organization and its constituency.

Congress of California Seniors ("CCS") is a statewide non-profit education and advocacy organization dedicated to improving the life of seniors and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS conducts research, analyzes issues and provides voter and consumer education to its members. Through an effective legislative committee, CCS initiates and monitors legislation, testifies at hearings and takes appropriate grass-roots action on pending and proposed legislation. When necessary, CCS initiates or joins in lawsuits to protect consumers and submits *amicus curiae* briefs to provide courts with insights it has learned from its members because of the vast body of real life experience they have acquired. The issues in this case impact, directly and indirectly, its entire constituency. Therefore, CCS is vitally concerned that the Court takes into account the effect its decision will have upon seniors in California and elsewhere across the United States.

California Coalition for Ethical Mental Health Care ("CCEMHC") is a non-profit group composed of mental health clients, family members, advocates, mental health professionals from all the disciplines licensed in California, and other interested members. The organization's mission is to advance access to quality, affordable mental health care through the coordinated efforts of mental health consumers and professionals. It promotes continuity of care, the patients' right to make informed choices when selecting treatment, and elimination of the use of pernicious financial

incentives that limit access to needed care. CCEMHC has an abiding interest in the issue presented in this case because it believes that health insurers and health plans should be held accountable for their treatment decisions and that health plan enrollees need unfettered access to the legal system.

SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act of 1974 ("ERISA") was designed as a shield to protect employees, rather than a sword that to be used against them. This Act, therefore, is turned on its head when health insurers and health plans, such as managed care organizations ("MCOs") and health maintenance organizations ("HMOs") use the Act's preemption provisions to avoid being held accountable for their wrongful delays and denials of coverage. This situation arises all too frequently since, as this Court has acknowledged, health plans have a financial incentive for delaying or denying expensive medical treatment. The instant cases demonstrate the harmful consequences that can result from the misuse of preemption.

The activities of Petitioners Aetna Health, Inc. ("Aetna") and CIGNA Healthcare of Texas, Inc. and CIGNA Corporation (collectively "CIGNA") *may very well* constitute medical malpractice. The U.S. Court of Appeals for the Fifth Circuit properly held that Juan Davila and Ruby Calad are entitled to pursue state claims for malpractice and to be compensated appropriately if they prevail in their claims. The holding that these claims were not preempted is in accord with what even Aetna and CIGNA recognize as the very purpose of ERISA: the protection of employees.

It is not surprising that Aetna and CIGNA, along with the rest of the health insurance industry, argue for a broad reading of the preemption provisions of the ERISA.

A broad reading enables health insurers and health plans to insulate themselves from state tort law claims that could otherwise deter them from delaying or denying treatment incorrectly. Petitioners would have this Court determine that the only consequences they could suffer from a wrongful delay or denial of treatment would be the benefits denied, i.e. the difference in value between the cost of the treatment eventually approved and the cost of the treatment that should have been approved. In other words, the only risk that health insurers and health plans would take, when they delay or deny treatment, is the risk that they would have to pay for it later on.

Such a structure has the inevitable effect of encouraging health insurers and health plans to delay or deny treatment. And that is a serious problem since the profit structure of such organizations provides an incentive to delay or deny treatment in the first place.

Petitioners contend that they are not denying "treatment," but merely are denying "coverage." From the employee's perspective, that is a distinction without a difference. No matter what words are used to couch the denial, the effect is the same: the treatment does not take place.

In fact, the fallacy in this argument is neatly illustrated by the facts of the cases at hand. In each case, the health plan did not merely deny treatment; it proposed an alternative. This Court has already recognized that when a health insurer or health plan denies one kind of treatment and requires a different one instead, it clearly is making treatment – not coverage – decisions.

All treatment decisions should be subject to state tort laws, whether those laws are statutory or at common law. Nothing in ERISA precludes this determination. To the

contrary, ERISA compels it. ERISA plan enrollees should not be deprived of the right to pursue legal claims that could make them whole against health insurers or health plans that wrongfully delay or medical treatment. Health insurers and health plans should not be allowed to insulate themselves from liability for any injuries that they cause. Courts should be allowed to consider whether such practices constitute medical malpractice, bad faith claims handling or another tort. There should be checks and balances on the built-in financial incentive that health plans and health insurers have to delay or expensive treatments, and to favor cheaper treatments – or no treatments at all.

For these reasons, Amici respectfully submit that the Fifth Circuit properly held that ERISA does not preempt state law tort claims, whether statutory or common law, under Section 502(a), 29 U.S.C. § 1132(a) and that this Court should affirm that court's decision.

LEGAL ARGUMENT

I. HEALTH INSURERS AND HEALTH PLANS SHOULD BE HELD ACCOUNTABLE UNDER STATE TORT LAW WHEN THEY CAUSE HARM BY WRONGFULLY DENYING MEDICAL TREATMENT

Under ERISA, health insurers and health plans are allowed to administer health plans for the benefit of enrollees.[2] Typically, they have the authority to approve or deny coverage for treatments that are recommended by the enrollees' treating physicians. This is the point where coverage decisions and treatment decisions converge. As a

[2] Enrollees of an ERISA plan for health insurance are, as beneficiaries of the ERISA plan, in essentially the same shoes as the policyholder in an ordinary insurance context. As such, the enrollee, like the policyholder, suffers the consequences of a denied claim. Further, enrollees pay fees, just like traditional premiums, for the health insurance.

practical matter, from an enrollee's perspective, a denial of "coverage" means that the enrollee does not receive the recommended treatment.

The essential issue here is whether a denial by a health insurer or health plan should be subject to state tort law remedies, both statutory and common law. Petitioners, along with the health insurance industry, say no, on the premise that a denial of coverage is a purely administrative decision that falls within the preemption provisions of ERISA. They say that the only recourse is the ERISA equivalent of breach of contract and the only remedy that should be allowed is payment for the treatment that was denied. Enrollees like Mr. Davila and Ms. Calad say yes, on the ground that such denials are medical, not administrative, decisions. They say that they should have recourse under state tort law for wrongful denials that cause them harm, and that they are entitled to all remedies that state tort law allows.

A. Improper Denials Cause Harm to Enrollees By Adversely Affecting Their Health And Also By Denying Them The Value of the Enrollee's Premium Payments

1. Aetna Denied the Medicine Recommended by Mr. Davila's Treating Physician and Prescribed An Ill-Fated Alternative

It is undisputed, in the case of Mr. Davila, that Mr. Davila's treating physician had prescribed Vioxx for Mr. Davila, that Aetna refused to pay for it, and that Aetna provided a generic painkiller instead. Aetna has admitted all of these essential facts.[3] Mr. Davila took the generic drug prescribed by Aetna and suffered bleeding ulcers as a result.

[3] See Brief for Petitioner Aetna Health, Inc. (Dec. 18, 2003) at 8-10 (characterizing the allegations in Mr. Davila's complaint).

Now, he cannot take any painkillers requiring absorption through his stomach – not even Vioxx, the drug his treating physician had prescribed. Thus, Aetna's so-called "coverage" decision failed to treat Mr. Davila's health problem and may have worsened it instead.

Aetna takes the position that, due to the preemption provisions of ERISA, Mr. Davila would not be allowed to sue Aetna even if Aetna had denied treatment to him in error and tortuously. Aetna contends that Mr. Davila's only available remedy is reimbursement of the price of the Vioxx that had been prescribed, less the price that Aetna paid for the generic drug. As noted by Aetna, this is the only remedy that ERISA would allow.

From an enrollee's perspective, such relief obviously would be insufficient. It certainly would not make Mr. Davila whole. It also would not deter wrongful denials in the future; to the contrary, it would affirmatively encourage health insurers and health plans to engage in wrongful denials. Thus, this case neatly illustrates the need to curtail preemption and thereby to prevent health insurers like Aetna from using ERISA as a sword against their policyholders.

2. CIGNA Denied the Hospitalization Recommended by Ms. Calad's Treating Physician, and She Promptly Suffered Medical Complications.

CIGNA, through a discharge nurse, refused to approve the request of Ms. Calad's treating surgeon to permit her to remain hospitalized after undergoing a hysterectomy involving rectal, bladder and vaginal repair. Instead, the nurse prescribed, or ordered, a discharge from the hospital. Shortly after CIGNA's nurse ordered Ms. Calad to be discharged, Ms. Calad was readmitted under

emergency conditions to treat complications from her surgery.[4]

CIGNA, like Aetna, now contends that the only remedy that can be sought by Ms. Calad is reimbursement of the cost of the hospitalization time that was denied. But, like Mr. Davila, Ms. Calad would not be made whole by such reimbursement. The injury to Ms. Calad goes beyond the cost of the denied hospital time. It includes the adverse health consequences that she suffered as a result of CIGNA's refusal to pay for it, and its provision of a wholly unacceptable alternative. As with Mr. Davila's case, this case illustrates why CIGNA should not be allowed to use preemption as a sword.

B. ERISA Plan Enrollees Need A Remedy That Correctly Addresses The Harms that They Suffer As A Result of Wrongful Denials.

When health insurers and health plans make improper treatment decisions, they should be subject to liability for the harm that they cause. The only way to hold them fully accountable is to subject them to state tort law claims, filed by the enrollees who allege that they were harmed. Administrative remedies under ERISA simply are not enough.[5]

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[4] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation (Dec. 18, 2003) at 3-4 (characterizing the allegations in Ms. Calad's complaint).

[5] If no tort claim may be brought, then no extra-contractual damages may be sought or recovered. Under ERISA's remedies, an enrollee seeking relief after a treatment denial by bringing an action for benefits due under the plan or for "appropriate equitable relief" and attorneys' fees. See 29 U.S.C. § 1132(a)(1)(b).

1. ERISA Does Not Permit Tort Claims Or Compensatory Damages

Statutory remedies under ERISA are narrowly drawn. Neither tort claims nor compensatory damages fall within the scope of the statute:

> [U]nder ERISA, there is no right to extracontractual damages or punitive damages .... The law is also clear that there is no right to a jury trial.[6]

It makes economic sense for health insurers and health plans to argue that ERISA has as broad a scope as possible "because the only relief available to an ERISA claimant is equitable relief, for which no right to jury trial exists."[7]

When an enrollee's complaints fall under the scope of ERISA, a health insurer or health plan can anticipate the potential value of its denial of a claim at the time the claim is denied. The potential remedy would be completely confined to reimbursement of the value of the treatment that was denied, reduced by the value of the treatment – if any – that actually was provided.[8] Such an approach may have

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[6] Allen, Elizabeth, P., *Long Term Care Insurance Litigation*, FOR THE DEFENSE (February 2003) at 25. FOR THE DEFENSE is a publication by and for attorneys who regularly represent insurance companies.

[7] Rapoport, Simeon, D. and Somervell, Katherine, S., *ERISA Trials Demystified*, FOR THE DEFENSE (February 2003) at 37.

[8] In effect, there would be little downside, and many potential advantages, for a health insurer or health plan to delay or expensive medical treatment. At worst, the damages will be the difference between the cost of the treatment approved or prescribed and the cost of the treatment originally sought by the enrollee – which would be nothing more than the amount that the health insurer or health plan had refused to pay in the first place. Many health insurers and health plans – when faced with a choice between pay-now-or-pay-later-(maybe) – simply would opt for the latter.

served valuable purposes in connection with the drafting of ERISA in 1974, especially considering that the statute's initial focus involved financial matters, such as the management of retirement benefit plans. Yet it is completely inappropriate in the context of health care, especially when the wrongful decisions for which a remedy is being sought concern vital and sometimes lifesaving medical treatment.

Additionally, applying such an approach to the denial of medical treatment and health care runs counter to the overall intent and purpose of ERISA.[9] The beneficiaries

[9] The use of ERISA preemption to deny claims brought by employees who have been denied medical treatment achieves the opposite affect intended by Congress when it enacted ERISA. See DeBofsky, Mark, D., Op-Ed Article, 30 THE INSURANCE FORUM 176. With regard to health care denials, the article states:

> • *Health Insurance.* The ERISA law is cited on a nearly daily basis to shield insurance companies from liability for denying life-saving medical treatment. So long as the insurer writes language into its policy stating that the insurer has discretion to decide who qualifies for benefits and under what circumstances, life and death decisions are insulated from meaningful judicial review. Even if the insurer is later found wrong, the absence of a damages remedy prevents lawsuits to redress the harm committed when a claimant dies as a result of being denied a prescribed life-saving treatment or a mother experiences the wrongful death of a prematurely born newborn infant because the insurer denies prenatal hospitalization.

DeBofsky goes on to point out that:

> Claimants are denied the right to trial by jury, a basic right afforded in insurance cases and virtually all other civil litigation. In most cases, claimants cannot even secure a trial before a judge since the case is decided based solely on the claim record applying procedures that favor the insurers both as to the interpretation of policy provisions as well as the manner in which evidence is reviewed. Employees also have no claim to any damages; no matter how egregious the insurer's or employer's conduct, the maximum recovery available is

who are supposed to benefit from ERISA are the enrollees, the employees, not the health insurance industry. This approach, however, principally benefits the latter, rather than the former.

C. Tort Claims Provide Much More Protection for Enrollees Than Statutory Remedies Provide Under ERISA – Especially When Consideration is Given to the Deterrent Effect

As explained above, this Court has recognized the inherent conflict within the business model of most health insurers and health plans. The conflict is that the business model establishes a financial disincentive for approving expensive medical treatment.[10] One way, and perhaps the only way, to balance out this financial disincentive is to create another financial disincentive for delaying or denying coverage wrongfully. That is what is created by the decision to allow ERISA enrollees to sue their health insurers and health plans in state court, and under state tort law, for wrongful coverage denials.

Indeed, tort claims have historically provided a deterrent to wrongful actions by insurance companies.

> the benefit sought plus the possibility of attorneys' fees awarded in the court's discretion. Thus, the worst that can happen to an insurer that withholds benefit payments, often for years after they are due, is that a court *may* require the benefits to be paid. No damages whatsoever are available for the harm caused as the result of wrongful withholding of benefits such as bankruptcy, home foreclosure, or even death if necessary medical treatment is denied.

[10] Pegram v. Herdrich, 530 U.S. 211, 234, 120 S. Ct. 2143, 2157 (2000) (recognizing that an HMO or HMO physician making a determine about medical treatment for a beneficiary must consider the for-profit incentive of sparingly providing treatment and that such a situation presents a conflict for the HMO or its physician).

Years ago, Richard Ellis, vice-president of claims at Mutual of Omaha Insurance Co., acknowledged that the insurance industry works hard to avoid being exposed to negative jury verdicts and judicial decisions:

> We're somewhat in a posture of doctor practicing defensive medicine . . . we're finding insurance companies paying claims and large settlements simply because of their fear of punitive -damage awards.[11]

Were there to be no opportunity for enrollees even to seek compensatory damages when a health insurer or health plan wrongly denied medical treatment, those companies would have every incentive to delay or claims and there would be no true check on that ability. The threat of liability under state tort law is necessary to provide that check and to ensure that enrollees have a way to deter health insurers and health plans from engaging in wrongful medical treatment determinations.

II. IF RESPONDENTS' STATE LAW TORT CLAIMS ARE HELD PREEMPTED, ENROLLEES WILL BE SUBJECT TO DENIALS OF TREATMENT WITHOUT RECOURSE

A. As Treatment Decisions, Or Mixed Decisions Of Eligibility And Treatment, The Petitioners' Decisions Are Not Preempted

Because ERISA does not preempt either (1) treatment decisions or (2) mixed eligibility and treatment decisions,[12] the simple issue here is whether the decisions made by

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[11] *Business Week*, August 15, 1983, pp. 118, 119.

[12] Pegram, 530 U.S. 211, 120 S. Ct. 2143.

Petitioners, Aetna and CIGNA, fall into either category. The simple answer is that they do.

Treatment decisions answer the question: "given a patient's constellation of symptoms, what is the appropriate medical response?"[13] Here, Aetna refused to approve the medicine prescribed by Mr. Davila's treating physician and provided an alternative instead.[14] Likewise, CIGNA, through a discharge nurse, refused to approve the treatment decision of Ms. Calad's treating surgeon and instead prescribed a discharge from the hospital.[15]

These factual scenarios are analogous to another case involving a mixed decision of treatment and eligibility that was held not preempted.[16] The HMO there, Vytra, and the HMO physician, Dr. Spears, examined an enrollee's "constellation of symptoms" and determined, ultimately, that the appropriate medical response was a single stem-cell transplant, not the double stem-cell transplant selected by Carmine Cicio's treating oncologist. This decision was held to constitute a mixed eligibility and treatment decision within the meaning of Pegram. It was found necessarily to require medical decision-making, as Vytra and Dr. Spears

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[13] Pegram, 530 U.S. at 228, 120 S. Ct. at 2154.

[14] See Brief for Petitioner Aetna Health, Inc., at 8-10.

[15] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation, at 3-4.

[16] See Cicio v. John Does 1-8, 321 F.3d 83 (2d Cir. 2003), petition for cert. filed, 72 USLW 3093 (July 11, 2003)(No. 03-69)(refusing to hold that common law medical malpractice claims based on an HMOs refusal of a double stem-cell transplant and the HMOs prescription of a single stem-cell transplant were preempted by ERISA). "Pegram demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component". Id. at 103.

decided on, then approved, a treatment that the treating physician had not recommended in the first place.

Aetna and CIGNA, in each respective instance, made an entirely separate "mixed eligibility and treatment decision" when they decided that Mr. Davila and Ms. Calad, respectively, should not receive the treatment that was recommended by their respective treating physicians. Each decision clearly incorporated treatment issues.[17] Just as in Cicio, the health insurers and health plans in these cases not only denied a particular treatment, but provided a patient-specific prescription by authorizing another treatment that had not been requested.[18]

These decisions also are comparable to decisions that were made by U.S Healthcare in another case, in connection with the treatment of Basile Pappas.[19] U.S. Healthcare, as plan administrator of Mr. Pappas' health plan, initially rejected a treatment recommendation made by the treating physicians: transfer to, and perform surgery at, a hospital that specialized in spinal cord injuries. After some delay, a transfer to a different hospital was approved instead. The Pennsylvania Supreme Court held that U.S Healthcare's

[17] See Pegram, 530 U.S. at 230, 120 S. Ct. at 2155.

[18] See Cicio, 321 F.3d at 104-05 ("Dr. Spears apparently made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another that [the treating oncologist] had not requested....we cannot identify distinct moments at which treatment decision as distinct from eligibility decisions were made").

[19] See Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001), cert. denied, U.S. Healthcare Sys. of PA v. Pennsylvania Hosp. Ins. Co., 536 U.S. 938, 122 S. Ct. 2618 (2002).

decisions constituted "mixed eligibility and treatment decisions."[20]

Thus, the plain language of Pegram, combined with the similarities between the decision-making here and in Cicio and Pappas, makes clear that the decisions here involve treatment decisions. For these reasons, Amici respectfully submit that the Fifth Circuit properly held that ERISA does not preempt state law tort claims, whether statutory or common law, under Section 502(a), 29 U.S.C. § 1132(a), and that this Court should affirm that court's decision.

1. It Is Not A Defense That Aetna or CIGNA Claims They Were Only Performing Utilization Review

Aetna and CIGNA both argue that their respective decisions regarding Mr. Davila's and Ms. Calad's respective treatment involve coverage only, as they were made in the course of utilization review.[21] This argument is completely wrong. In short, whenever physicians or managed care organizations make decisions about the treatment that patients should receive, they are making treatment-related decisions. Health insurers and health plans should not be able to evade responsibility for the consequences of such decisions by engaging in an exercise in semantics: i.e., by

[20] Id. 768 A.2d at 1096. "[T]he treating physician did not, in the Supreme Court's words, only make a "'simply yes or no' decision as to whether Pappas' condition was covered; it clearly was. Rather [he] also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law." Id.

[21] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation, at 3-4, and Brief for Petitioner Aetna Health, Inc., at 8-10.

simply saying these decisions regard coverage rather than treatment.[22]

B. Traditional State Tort Claims Are Not Preempted By ERISA, But Compliment ERISA

Pegram makes clear that "treatment decisions" and "mixed eligibility and treatment decisions" are subject to state law, and are not preempted by ERISA.[23] This analysis comports with prior holdings that the "historic police powers of the state include the regulation of matters of health and safety,"[24] and that "the historic police powers of the states were not to be superseded by the federal act [ERISA] unless that was the clear and manifest purpose of Congress."[25]

[22] In a hearing before Congress in 1999, the American Medical Association (the "AMA") stated that "medical necessity decisions are ultimately medical decisions and should continue to be treated as such. [They] must always be made in accordance with those generally accepted standards of medical practice that a prudent physician would follow when treating a patient." Employer Health Plan Accountability: Do Plan Participants Have Adequate Protections?: Hearing Before the House Subcomm. on Employer-Employee Relations, House Comm. on Educ. and the Workforce, 106th Cong. 127 (1999) (Statement of Timothy T. Flaherty, M.D., American Medical Association). Available at http://commdocs.house.gov/committees/edu/hedcew6-24.000/hedcew6-24.htm.

[23] Pegram, 530 U.S. at 235, 120 S. Ct. at 2157-58.

[24] See DeBuono v. NYSA-ILSA Medical & Clinical Services Fund, 520 U.S. 806 (1997).

[25] N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 653-655 (1995). Clipping the wing of the state judiciary is inconsistent with the McCarran-Ferguson Act. The state judicial system is in place to punish insurance companies for wrongful conduct and provide relief for injured parties.

The Savings Clause of the United States Constitution itself protects the states' historic powers and also applies to the ERISA. The Savings Clause necessarily limits implied preemption under ERISA § 502 and state law remedies protected by the Savings Clause would defeat implied preemption under § 502.[26]

ERISA does not provide that Congress intended to preempt state law in the traditionally state-regulated area of health and safety.[27] There is no provision in ERISA that states that it preempts every state law claim relating to ERISA plans.[28] Professor Bogan further points out that both § 502(a) and § 514 are part of the same sub-section and that § 514 provides that "'nothing in this sub-section of ERISA shall be construed' to preempt state insurance regulations."[29]

[26] Bogan, Donald, T., *Fifteen Reasons Why ERISA Does Not Preempt State Law Bad Faith Claims*, ATLA TRIAL MAGAZINE, XXXIV, 4 (April 1, 2003) at 7 (citing, as part of reason 1, Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 25 (1983) which states that "Congress did not intend to preempt entirely every state cause of action relating to [ERISA] plans" because it expressly does not exempt plans from any state laws that regulate insurance). In the instant cases, the state law claims are based on statutory causes of action specifically codified by the Texas legislature.

[27] ERISA provides only that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

[28] Bogan, at n.29 (again citing Franchise Tax Bd., 463 U.S. at 25. Professor Bogan also states that many district courts have recognized that express preemption under ERISA § 514 does not preempt state tort claims. Id. at 3-4 and n.16 (citing this Court's decision in New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)).

[29] See id. at 11 (explaining this language as reason no. 10 of his "fifteen incontrovertible reasons").

Notably, in the text of the statute, "hospital" appears only once and "physician" not at all.[30] This Court has stated that "[n]othing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[31]

The absence of language specifically preempting state law claims in § 502 is in contrast to the clear language of the McCarran-Ferguson Act. That act specifically states that "No act of Congress shall be construed to invalidate ... any laws enacted by any State for the purpose of regulating the business of insurance."[32] Further, § 514 expressly states that it shall not be construed to supersede any other federal law.[33]

Moreover, the very preamble of ERISA provides that it is intended to protect employees.[34] Petitioners'

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[30] Billie Elliott McAuliffe, *The Changing World of HMO Liability Under ERISA*, 22 J. LEGAL MED. 77, 86 (March 2001).

[31] Travelers, 514 U.S. 645, 661, 115 S. Ct. 1671, 1679-80. See also Pegram, 530 U.S. at 235, 120 S. Ct. at 2157-58. Amicus believes that this necessarily includes both sections 502(a) and 514, as argued by the Respondents in these consolidated appeals.

[32] 15 U.S.C.A. § 1012(b) (West 2003). See Sharon J. Arkin, *Memorandum Re: California Bill SB21* (2001), available at http://www.harp.org/arkin.htm, (stating that ERISA health plan administrators, such as MCOs and HMOs, already are subject to numerous state law regulations despite ERISA's preemption provisions).

[33] Bogan, at 11 (explaining as reason 11 that ERISA does not and cannot supersede the McCarran-Ferguson Act that specifically reserves state law tort claims, such as the ones at issue in this case, to the powers of the various states).

[34] Bogan, at 12-13 (stating that ERISA's preamble, and its legislative history, confirm that it is intended to help assure plan participants actually received the benefits they were led to believe they would receive).

arguments ignore that intention. The limited protection provided to health insurers and health plans is based on contractual, not tort, duties and that protection is not intended to supplant traditional tort-based duties or standards of care.[35]

C. This Court's Reasoning Has Assumed The Availability To Enrollees Of State Law Tort Claims

This Court has recognized that the business model of health insurers and health plans creates an incentive to deny expensive treatments and prescribe the least expensive alternatives.[36] This Court has described how health insurers and health plans often provide similar incentives to doctors with the lowest cost per patient.[37] Further, that incentive runs counter to any duty to consider the enrollee's treatment as the first priority.

> The fiduciary is, of course, obligated to act exclusively in the interest of the beneficiary, but this translates into no rule readily applicable to HMO decisions .... While the incentive of the HMO physician is to give treatment sparingly, imposing a fiduciary obligation upon him would not lead to a simple default rule...[38]

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[35] Cicio, at 99 (citing Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147-48 (1985); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S. Ct. 948 (1989) and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138, 111 S. Ct. 478 (1990)).

[36] See Pegram, 530 U.S. at 223, 120 S. Ct. at 2151.

[37] See id. at 219, 120 S. Ct. at 2149 (describing how HMOs are designed to reward physicians financially for providing less treatment and for providing less expensive treatment).

[38] Id. at 234, 120 S. Ct. at 2157.

This Court went on to state that that ERISA does not create for enrollees a fiduciary claim against HMOs since, "for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed [eligibility and treatment] decision would boil down to a malpractice claim."[39] That explanation assumes the availability of state tort claims that may be used to make whole an enrollee who was improperly denied medical treatment.

Having closed the door on a federal, ERISA based remedy that allows enrollees to recover the full value of damages they suffered, this Court cannot adhere to its own reasoning if it now decides to limit enrollees' ability to bring state tort claims, such as malpractice claims.

D. State Legislatures Across The Nation Also Have Recognized The Inherent Need For Tort Law Protection Of ERISA Enrollees

In recent years, policymakers and regulators across the country have recognized, formally, that utilization review constitutes medical decision-making. For example, the AMA's current policy on the topic is "that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine."[40]

State regulators are increasingly in accord. For example, in 1997, the Texas State Board of Medical

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[39] Id., at 235, 120 S. Ct. at 2157.

[40] AMA Policy H-285.939, Managed Care Medical Director Liability. Available online at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-285.939.HTM&s_t=H-285.939&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&. The concept of "the practice of medicine" is analogous to the concept in Pegram of "treatment decisions" and "mixed treatment and eligibility decisions." See Pegram, 530 U.S. at 235, 120 S. Ct. at 2154.

Examiners decided that "the determination of medical necessity or appropriateness of proposed care so as to effect the diagnosis or treatment of a patient is the practice of medicine."[41] In 1998, the California State Medical Board passed a resolution that "the making of a decision regarding the medical necessity. . . of any treatment constitutes the practice of medicine."[42]

In 1999, the Louisiana State Board of Medical Examiners held that "the requirement that the act of determining medical necessity or appropriateness of proposed medical care so as to effect the diagnosis or treatment of a patient in Louisiana is the practice of medicine."[43] Also, in 2001, the South Carolina Board of Medical Examiners declared that "the act of determining medical necessity or appropriateness of proposed medical care, so as to affect the diagnosis or treatment of a patient located in South Carolina, is the practice of medicine."[44]

More regulation of this type is likely, as such regulation is expressly advocated by the Federation of State Medical Boards of the United States, Inc. In 1998, this entity advised its membership, which includes the medical boards of all states and the District of Columbia, that "[s]tate medical boards, through legislative or regulatory process, should amend their medical practice acts or appropriate statutes to include the determination of medical necessity or

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[41] Texas State Board of Medical Examiners, Medical Board Report, Vol. 18, No. 2 (Spring 1997), available at http://www.tsbme.state.tx.us/news/Spring97/spring97.htm.

[42] See Silicon Valley San Jose Business Journal, June 5, 1998.

[43] See La. Op. Att'y Gen. No. 98-491, 1999 WL 288869, p.2 (Apr. 27, 1999).

[44] See Policy Statement approved at February 5-7, 2001 Board Meeting, available at www.llr.state.sc.us/POL/Medical/Medical%20Necessity.htm.

decisions affecting the diagnosis and/or treatment of a patient as the practice of medicine."[45]

Many states have begun to regulate health insurers and health plans, like MCOs and HMOs, more closely. [46] For example, Minnesota passed a law establishing that its Board of Medical Practice has jurisdiction to take action against utilization review physicians whose judgments violate the standard of care.[47] And, in 1995, the Florida Agency for Health Care Administration issued a cease and desist order against Roger Strube, a medical director of a Florida-based managed care organization. It alleged that he practiced medicine without a license in Florida by making utilization review decisions.[48] This agency decision appears to turn on facts analogous to those here, where a nurse at CIGNA refused to accept a treating physician's recommendation and prescribed other treatment.

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[45] Report of the Special Committee on Managed Care, S III.C., (May 1998), available at www.fsmb.org.

[46] Barry Gold, *Vulnerability of HMO Physicians Who Make Medical Necessity Decisions to Professional Misconduct Proceedings by State Licensing Agencies*, Presentation at New York State Bar Assn. Annual Convention (Jan. 26, 2000); see also National Conference of State Legislatures, *Major Health Care Policies: 50 State Profiles, 2001* (Jan. 2002) at 4 (listing Colorado, Florida, Iowa, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Michigan Minnesota, Missouri, Montana, New Jersey, New York, North Carolina, Rhode Island, Tennessee and West Virginia as states considering statutory liability for health insurers and health plans). During 2001 alone, New Jersey, North Carolina and West Virginia adopted such laws. Id.

[47] 2001 Minn. Laws 147.091, Subd. 1b.

[48] See Agency for Health Care Administration, Notice to Cease and Desist, at 1, In re Unlicensed Practice of Med.: Roger H. Strube, No. 9420668 (filed Feb. 24, 1995). The Agency did so even though Dr. Strube was licensed in two other states.

Some courts also have addressed cases arising from such state laws, and allowed them to proceed.[49] The Missouri Supreme Court cited Murphy with approval in evaluating the state medical board's jurisdiction over a medical director who propounded pre-certification decisions.[50] That court expressly found that jurisdiction was proper because the medical director's decisions were not administrative but medical:

> The determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision about the "medical necessity" of surgical treatment for a particular patient.[51]

Other states have begun to consider the passage of legislation that would increase the requirements placed upon HMOs.[52] For example, the State of New York announced in 1998 that the Office of Professional Medical Conduct will investigate complaints regarding denials of care made by medical directors of managed care organizations.[53]

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[49] See e.g., Murphy v. Board of Medical Examiners, 949 P.2d 530 (Ariz. App. 1997), in which the Arizona Court of Appeals ruled that the State Board of Medical Examiners had jurisdiction over a state-licensed physician who denied pre-certification for gallbladder surgery, on behalf of a managed care organization.

[50] State Board v. Fallon, 41 S.W.3d 474 (2001).

[51] See 41 S.W.3d at 478.

[52] See The Limited Liability of Corp. Health Maintenance Org., 39 Dec. TNBJ 27, 35 (Dec. 2003)(listing Arizona, California, Georgia, Maine, Massachusetts, North Carolina, Oklahoma, Texas and Washington).

[53] MSSNY, News of New York, Oct. 1998, p.5.

In addition, a majority of states, including New York, have passed legislation requiring medical directors of managed care organizations to be licensed as physicians.[54] Such legislation is significant because it puts the lie to the contention that utilization review regards coverage alone. If that were true, then there would be no need for the "utilization reviewers" to be licensed physicians. Thus, the Medical Society of the State of New York ("MSSNY") and other organizations call for regulations that:

> [w]i.. declare that any person making decisions on the medical necessity or appropriateness of care affecting the diagnosis or treatment of a patient in New York must have a license to practice medicine in New York; and that a physician making decisions on the medical necessity or appropriateness of care affecting the diagnosis or treatment of a patient in New York without a valid New York license, as well as the company that employs him/her, will be subject to investigation, criminal prosecution and possible fines.[55]

In addition to New York, states with such laws include Alabama, Arizona, Arkansas, California, Colorado,

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[54] Tanya Albert, "Higher Accountability for HMO Medical Directors," amednews.com (May 14, 2001), available at http://www.ama-assn.org/amednews/2001/05/14/prl20514.htm ("In the past several years, more than half of the nation's stat· have passed laws requiring HMO medical directors to be licensed physicians. And medical directors who are licensed physicians are increasingly being held responsible by state medical boards." In fact, the Federation of State Medical Boards mandates the passage of such legislation. See n.14, supra, at III.D ("State medical boards must, through legislative or regulatory process, require that MCO medical directors hold current and unrestricted medical licenses in the states in which the patients of the plan reside").

[55] MSSNY Position Statement § 165.969, available at http://www.mssny.org/position/managed.htm (Jan. 21, 2004).

Delaware, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Rhode Island, South Dakota, Texas, Vermont, Virginia and Wisconsin.[56]

Finally, this Court made clear in Pegram that a number of states permit malpractice actions against HMOs, and that such actions are consistent with ERISA.[57] In recent years, five states - Texas, Georgia, California, Arizona and Washington - have passed laws expressly giving consumers expanded rights to sue their HMOs. Other states actively are debating similar legislation.[58]

These policies, regulations, laws and decisions collectively illustrate decisions such as those made by Aetna and CIGNA in these cases are widely considered to involve the practice of medicine, and "mixed eligibility and treatment decisions." Semantics aside, the outcome is clear. The decisions are subject to liability under state law and fall outside the scope of preemption.

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[56] See National Conference of State Legislatures, *Major Health Care Policies: 50 State Profiles, 2001* (Jan. 2002) at 28-31, Table 2, and passim in the state sections. See also *Major Health Care Policies*, at 4 (listing New Jersey, North Carolina and West Virginia as having adopted statutes during 2001 that afford direct liability against health insurers and health plans for treatment decisions).

[57] Pegram, 530 U.S. at 236, 120 S. Ct. at 2158. In fact, one reason the Court offered for failing to recognize a breach of fiduciary action under ERISA was that such an action could be seen as "a prescription for preemption of state malpractice law. . . ." As shown by Pappas and Vytra supra, such cases have proceeded under state common law in state and federal courts.

[58] Phyllis C. Borzoi, *Erisa and Managed Care Plans: Key Preemption and Fiduciary Issues*, SF28 ALI-ABA 371 (Oct. 2000) at 423 n.2.

III. STATE LAW TORT CLAIMS ARE NECESSARY TO DETER WRONGFUL DENIALS OF MEDICAL TREATMENT AND HEALTH CARE

A. Health Insurers and Health Plans Receive The Same Payment For Their Product Whether Or Not They Deny Treatment

Unlike most products, after health insurance policies and plans are sold, the buyer wants it to work, but the seller does not.[59] Health insurance policies and health plans are aleatory, meaning that the enrollee performs first, by paying premiums while the health insurer or health plan performs later, but only if a claim for treatment is made.[60] The nature

[59] "Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to "play the float" in any dispute." Jeffrey W. Stempel, *Interpretation of Insurance Contracts: Law and Strategy for Insurers and Policyholders*, § 19.3, at 466-67 (1994).

[60] Comparing the insurance transaction to purchasing a car highlights the difference. When one contracts for a Cadillac, and is tendered a Yugo, one may cancel her check and go to another car dealership. An enrollee, however, who is promised Cadillac insurance at the point of sale and receives Yugo insurance at the point of treatment cannot "recover" by going back in time.

of the contract provides the insurer or plan with a future advantage, namely, economic leverage.[61]

Prior to the time of treatment, it is difficult to evaluate the quality of the health insurer or health plan. As explained above, at the time of treatment, an enrollee is at a distinct economic disadvantage already having "lost" the premium, unable to independently afford the medical treatment and already being ill. Time is often crucial to the enrollee needing treatment, while the health insurer or health plan may comfortably use time to its advantage.[62]

As in the case of Mr. Cicio, the patient may not even live to see the outcome of his lawsuit against his health insurer and health plan.[63] If an enrollee's potential damages were capped at the cost of the treatment denied, it could be pointless to file a lawsuit.

[61] Pegram states this principle as it is applied to an HMO, rather than a traditional insurance company:

> The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed. The HMO thus assumes the financial risk of providing the benefits promised: *if a participant never gets sick, the HMO keeps the money regardless,*...cost-controlling measures are commonly complemented by specific financial incentives to physicians, *rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment,* ...

Pegram, 530 U.S. at 219, 120 S. Ct. at 2149 (citation omitted)(emphasis added).

[62] See Cicio v. John Does 1-8, et al., 321 F.3d 83, 87-88 (2d Cir. 2003)(detailing the health plan enrollee's missed opportunity to receive particular treatment because the insurance company would only communicate with the enrollee's physician by letter and required three weeks to a month to respond to each letter). In Cicio, the enrollee actually passed away prior to the resolution of his lawsuit.

[63] Cicio, 321 F.3d at 88.

The heavily tilted playing field favoring health insurers and health plans has not gone unnoticed by courts. Even the dissent in Cicio recognized that inherent injustice that would result if enrollees had no ability to seek compensatory damages when health insurers or health plans improperly denied treatment. "The conclusion that my colleagues have reached … [that her tort claims are not preempted]. may provide justice to Mrs. Cicio, and I'm glad for that...."[64]

The instant cases now provide this Court a valuable opportunity to make clear to everyone who is enrolled in an ERISA plan, along with the entire health insurance industry, that state laws – including both statutory and common law – are available to protect enrollees under ERISA against wrongful actions by health insurers and health plans.

B. Health Insurers and Health Plans Could Use "Opportunistic Breaches" To Their Advantage, Without A State Law Remedy

Without the threat of compensatory damages, health insurers and health plans would be free to delay or treatment and prescribe less expensive treatment without any consequences. In fact, a practice of institutionalizing wrongful denial would be a rational business plan, as it would maximize profits and minimize costs. Such a scenario would run completely counter to the intent of Congress in creating ERISA: the protection of employees.[65]

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[64] Cicio, 321 F.3d at 106 (Calabresi, J. dissent).

[65] Cicio, 321 F.3d at 99 (stating that "Indeed, one of ERISA's stated goals involves increasing 'the likelihood that full benefits will be paid to beneficiaries…")(citing 29 U.S.C. § 1001b(b)(1)); see also Bogan, at 7 n.31 (citing, as part of reason 2, Humana v. Forsyth, 525 U.S. 299, 312, 119 S. Ct. 710, 718 (1999) for the proposition that ERISA is intended to protect employees and, therefore, there can be no preemption of state law tort claims that are (inherently) extra-contractual, because they supplement ERISA's protection of employees rather than conflict with it).

It is well recognized that health insurers and health plans increase profits by delaying and denying claims and that by delaying and denying claims those companies may be exercising "opportunistic breaches."[66] Opportunistic breaches are precisely what enrollees would be forced to endure if they could not bring tort claims against health insurers and health plans that wrongfully delay or medical treatment under ERISA plans. Health insurers and health plans, along with their senior executives,[67] would have every incentive to delay or claims under that scenario.

CONCLUSION

The party that holds the purse strings, whether a traditional insurance company or a managed care organization, should not be permitted to be the ultimate arbiter of its own self-interested decisions. It is a poor idea, and possibly a fatal own, to give such entities complete autonomy, along with a financial incentive to delay or claims and a lack of financial exposure for any consequences. State tort laws – both statutory and common law – provide a much-needed antidote, and the instant cases provide an opportunity for this Court to apply it. For all of these reasons, *Amici* respectfully urge this Court to render a decision establishing that state tort law claims are not preempted by ERISA. *Amici* respectfully suggest that the judgment of the United States Court of Appeals for the Fifth Circuit should be affirmed.

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[66] Since insurance companies have an incentive to force litigation to lower overall claim payments, "[o]pportunistic breaches are especially likely, and traditional damage rules do not sufficiently deter them." Pennington, *Punitive Damages for Breach of Contract: A Core Sample from the Decisions of the Last Ten Years*, 42 Ark. L. Rev. 31, 54 (1989).

[67] Pegram, 530 U.S. at 219, 120 S. Ct. at 2149 (explaining that HMOs make a profit by providing less treatment and charging fixed fees). Thus, any employees of an HMO whose compensation is tied to profits has an incentive to provide the least expensive care to patients.

Respectfully submitted,

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